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ABSTRACT

The joint committees met to examine the long-term care problems faced by the Indian elderly and to consider various proposals to resolve those problems. Four expert panels and 10 government and tribal representatives presented testimony on the health problems of the Indian elderly. One expert panel consisted of representatives of the Bureau of Indian Affairs, the Indian Health Service, the Health Care Financing Administration, and the Administration on Aging. The remaining three panels consisted of tribal representatives including Navajo, Pueblo, Apache, Oglala Sioux, Yakima, Cheyenne River Sioux, and Omaha. Testimony touched on funding, federal responsibility for long-term health care, coordination of agency services, Medicare/Medicaid programs, nursing home policy, and specific provisions of the Older American Act. The bulk of this document consists of material submitted for the hearing record. In addition to prepared statements by panel members, materials include reports submitted by southwest tribes, the New Mexico Title VI Indian Coalition, the New Mexico Indian Council on Aging, the Inter-Tribal Council of Arizona, and Senator deConcini of Arizona. The Long-Term Care Gerontology Center of the University of Arizona submitted two papers concerned with American Indian nursing homes. (JHZ)

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# LONG-TERM CARE FOR THE INDIAN ELDERLY

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# OVERSIGHT HEARING

BEFORE THE

## SELECT COMMITTEE ON AGING

AND THE

## COMMITTEE ON
## INTERIOR AND INSULAR AFFAIRS
## HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

LONG-TERM CARE FOR INDIAN ELDERLY

HEARING HELD IN TUCSON, AZ
MAY 25, 1984

SELECT COMMITTEE ON AGING
SERIAL NO. 98-475

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
SERIAL NO. 98-45

Printed for the use of the Select Committee on Aging
Committee on Interior and Insular Affairs

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# LONG-TERM CARE FOR THE INDIAN ELDERLY

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FRIDAY, MAY 25, 1984

House of Representatives,
Select Committee on Aging,
Committee on Interior and Insular Affairs,
*Tucson, AZ.*

The joint committees met, pursuant to notice, at 9 a.m., in the Student Union Senior Ballroom, University of Arizona, Tucson, AZ, Hon. Edward R. Roybal (chairman of the Select Committee on Aging) presiding.

The Chairman. The meeting will now come to order.

Ladies and gentlemen, it is a pleasure for me to be here in Tucson, on the beautiful campus of the University of Arizona. The hearing today is a joint effort between the Select Committee on Aging and the Committee on Interior and Insular Affairs, chaired by your Congressman, Mo Udall. Our purpose is to examine the long-term care problems faced by the Indian elderly and to consider various proposals to resolve these long-term care concerns.

In the United States today, there are an estimated 109,000 native Americans age 60 and over. In 1970, this population numbered 64,000. It is also estimated that about 5 percent, or 4,360, Indians age 60 and over are in long-term care facilities at any given time. But the fact of the matter is that there are only eight long-term care facilities on Indian reservations with a total bed capacity of 410 beds. What this means is that the Indian elderly are being placed in non-Indian facilities away from the Indian communities.

This situation needs to be changed. It is time for a coordinated effort by the Medicare/Medicaid Programs, the aging programs, the Indian Health Service, State and local governments, and the private sector long-term care providers. I believe that through this joint and coordinated effort we can pool our limited resources and bring about a long-term care system that meets the needs of the Indian community.

Many of the health problems faced by Indian elderly are unique and require special solutions. Today we will receive testimony from panels of experts who will provide us with more insight into these special problems and with recommendations as to how we can begin to address them.

Before we hear from the first panel, I want to give special thanks to the University of Arizona for allowing us to use these excellent facilities, and to the staff of the Arizona Long-Term Care Gerontology Center for assisting us in the preparations for this hearing.

Ladies and gentlemen, this is a joint hearing of two committees of the House of Representatives. We sincerely hope that the information that we receive today can be put into meaningful legislation or at least meaningful solutions. This would help the various existing agencies to coordinate their functions, thereby providing an effective delivery system to the Indian community of the United States. That is our expectation, and we look forward to the testimony that will be given by experts in this field.

Before doing that, I would like to recognize the gentleman from Arizona, Mr. McNulty.

Mr. McNULTY. Good morning, everyone. We welcome you most cordially to the State of Arizona.

Mr. Roybal is Chairman of the Select Committee on Aging of the U.S. House of Representatives, a position in which he succeeded another very famous name to people interested in the problems of the aging—that of Senator Claude Pepper.

As an alumnus of the University of Arizona, I welcome you here especially to the campus.

It is true, the Interior Committee has responsibility for matters dealing with Indians. During this past year and a half, Congressman McCain and I have undertaken a lot of the work in connection with problems dealing with Indians.

Because of the Interior Committee's jurisdiction over Indian matters, Chairman Roybal asked Chairman Udall to join in these efforts. Chairman Udall we expect in a few hours. He is coming in this morning from Washington. But we will get under way as we had planned.

This is to be a forum to hear tribal concerns, recommendations about problems providing adequate care for Indian elderly. And the problems associated with coordinating Federal resources for the long-term care of the elderly is a big one.

This is not the first time there has been a congressional review of these issues. In December 1981, a Senate Select Committee on Indian Affairs conducted a similar hearing back in Washington. From that hearing record, we have a history by which we can measure tribal progress and Federal progress I think we have accepted our responsibility to address the issues as yet unresolved.

One of our committees' concerns is how do we promote Federal responsiveness to tribal concerns in establishing community-based or home-oriented care facilities for the elderly? An older person, in our view, can continue to be an active and contributing member to society in his or her community if there are adequate support services available.

I am hopeful the hearing will provide us with an active accounting of what are the primary responsibilities of the four Federal agencies charged with this responsibility. We want to know what the policy is of those agencies with respect to fulfilling the goals established under directives to these needs; and we want to better understand how these agencies interact with one another, or fail to, as the case may be.

I expect the tribal witnesses we hear from today are going to provide the committee with some information on how the agencies can improve and expand their activities and assist tribes in helping the elderly to lead a useful life—in many instances, active and contributing forces in their communities. We know many of the problems associated with providing those services are due to insufficient funding. Money seems to be at the root of many of these things.

But, beyond that, we think that additional help can be provided in terms of setting up a comprehensive and, I would hope, flexible tribal effort. The coordination of the programs within existing structures with limited resources I think ought to be the first step before we get into trying to imagine some enormous bureaucracy.

Long-term action is going to depend on how well we articulate Federal policy regarding care for Indian elderly and what resources we will direct to that effort. We want to work with the Select Committee on Aging.

We are most grateful to you, Chairman Roybal, for this opportunity this morning.

And, most importantly, we want to work with the Indian people in determining how to define the Federal responsibility and how to set up the appropriate way to meet that responsibility.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The Chair now recognizes Mr. McCain.

Mr. McCAIN. Thank you, Mr. Chairman.

I would like to first express my appreciation to you, Mr. Chairman, and also to my fellow Arizonan, Chairman Udall of the Interior Committee, for holding this hearing.

I have had a great deal of gratification in working with Mo Udall and Jim McNulty on Indian issues. I am a member of both the Aging Committee as well as the Interior Committee. I also serve as chairman of the Republican task force on Indian affairs.

I am happy to join in welcoming the witnesses who will be providing us with valuable testimony on issues affecting the provision of long-term care and social services to elderly American Indians and Alaskan Natives.

It is my understanding that what was alleged 3 years ago by the National Indian Council on Aging is regrettably true today—there is no Federal long-term care policy; nor is there a coordinated system of long-term care that ensures that Indian elderly can live in dignity, independence, and harmony with their family, community, and culture. I further understand that existing programs do not provide a continuum of care that includes both health and social services, and that this is also true for nonelderly Indians whose physical or mental conditions require long-term care.

I look forward to exploring with the witnesses whether these understandings are accurate. I look forward to hearing testimony from representatives of the Bureau of Indian Affairs and the Indian Health Service, whose programs do provide some long-term care. I am particularly interested in the nature and extent of cooperation between those two agencies in providing such care.

Similarly, I look forward to hearing the testimony from the Health Care Financing Administration, which administers Medicare and Medicaid. I would appreciate hearing from the Federal agency witnesses an assessment of the Arizona alternative to the Medicaid Program, the Arizona health care cost containment system.

In particular, I would appreciate a discussion of the practical effects, both programmatic and budgetary, of the AHCCCS Program on Federal programs providing health care services to Indians both on and off reservation. A key question is whether AHCCCS has the effect of burdening local counties and/or the Federal programs with health care costs that in all other States are borne by State Medicaid programs.

To the witnesses from Indian tribes and organizations, I would say that while I appreciate the need for culturally attuned nursing facilities, I believe that emphasis for long-term care should be given to community-based, home health care and social services. Your views on this bias will be welcomed.

Mr. Chairman, this concludes my opening remarks, except to say that it is altogether appropriate that this hearing be held in May, in that both Congress and the President have declared it to be "Older Americans Month."

I might add, as a resident of Tempe I hope the next hearing will be held at Arizona State University.

Thank you, Mr. Chairman.

The **Chairman**. I can assure the gentleman that his last request will be taken under consideration.

It is indeed a pleasure for me to welcome the members of the first panel: Dr. Anderson, Ms. Elaine Quiver, Roland E. Johnson, Dr. Annie Wauneka, and Mr. Ray Olney.

Dr. Anderson, will you please start off the discussion.

[Additional materials submitted for the hearing record from Ned Anderson; Elaine Quiver; Vincenti Pedro, Sr.; Annie Wauneka; and Ray Olney may be found in the appendix.]

## PANEL CONSISTING OF NED ANDERSON, TRIBAL CHAIRMAN, SAN CARLOS APACHE TRIBE, REPRESENTING INTERTRIBAL COUNCIL OF ARIZONA; ELAINE QUIVER, DIRECTOR, FOSTER GRANDPARENTS PROGRAM, OGLALA SIOUX TRIBE; ROLAND JOHNSON, CHAIRMAN, BOARD OF DIRECTORS, LAGUNA RAINBOW CORP., ON BEHALF OF VINCENTI PEDRO, SR., GOVERNOR OF THE PUEBLO OF LAGUNA; DR. ANNIE WAUNEKA, REPRESENTING NAVAJO TRIBAL COUNCIL; AND RAY OLNEY, REPRESENTING YAKIMA TRIBAL COUNCIL

Mr. **Anderson**. Ed Roybal, Jim McNulty, John McCain: I would like to welcome you to Arizona. To the two of you from Arizona, welcome back.

My name is Ned Anderson. I am tribal chairman of the San Carlos Apache Tribe. There are 19 other member tribes within the organization. I represent the 20 tribes.

I have with me in person today Millie D. Steel. She is 72 years of age, a fullblooded Apache. And I was also going to have Irene Patton. She is 88 years of age. But because of the Tucson weather, she could not come today.

I am going to be using three real cases that I came across within a span of 1 week, and that was only last week. Before I go into these real cases, however, I would like to emphasize that the life expectancy among Indians in the United States is 47 years. These two—Millie and Irene—are the ones who have lived beyond their life expectancy.

Unlike Richard Lamm, Governor of the State of Colorado, we, the Indians, believe that we should keep our elderly people around until the end, no matter what their status, health, or otherwise. Without the elderly, we would not be here today. You, the congressional leaders, would not be holding hearings today without your elderly relatives.

You know, and we know, that the elderly people are our roots. We read about history. We try to teach it. We try to understand history. Without the elderly people, our history would not have been what it is.

They play a vital role in our homes, and that is especially so in an Indian society. You see, ours is a matrilineal society. We place great value in our grandmothers, our mothers, and also in our grandfathers and our fathers. Without them, there would not be a society as ours is today.

I am going to use three real cases to make my points today. And, as I said earlier, I came across these cases in a span of 1 week—last week.

Irene Patton, who is not here today, as I told you, because of the weather situation here in Tucson, is 88 years old. She has been a resident of our shelter care center in San Carlos, and she suffered a stroke in the past, and she now, because of that, suffers involuntary body movement. The stroke affected the part in her brain that controls body movement.

Irene has now reached a stage in her life where she will need constant skilled nursing home type care. Our community shelter care facility is not equipped to provide this type of care. As a result, she became a candidate for an off-reservation nursing home. But her children do not want her to be placed there. They are looking for a place today to rent on the reservation. A daughter has offered to quit her job in Phoenix so she can return to the reservation to live with and care for her mother.

Millie D. Steel, who is right here beside me, is 72 years old and has suffered from an illness that she probably derived by taking in food that has been given by modern society. Our people used to live off the land, as you know. Whatever food they took in, it was because of the nourishment that it provided. But I will get into that ailment after a while.

She has been a resident of an off-the-reservation nursing home. Currently, she is living with her daughter, who is here in the audience. Why? Because on several visits made by her daughter and her friend to this off-the-reservation nursing home she was found unattended in a bathtub for several hours.

Millie is suffering from crippling arthritis. Our people never used to have such ailment. That is because of the types of nourishments that our people took, which was from Mother Earth—instead of the synthetics that we now get from the markets.

Millie is the wife of Willie Steel, a disabled veteran who is 59 years old and has been confined at a veterans institution in Pasadena, CA, the last 35 years. Willie served in World War II, a war that you and I are still reading about today. He only remembered being bombed by the enemy and receiving a blow or a bump to his head. He suffers memory loss and takes medication daily for a nervous disorder.

The San Carlos Tribe is now in the process of having Willie returned to his family in San Carlos. Even as to this process, there are bureaucratic white tapes. I don't want to use the word or term "redtape." But we are going to surmount those white tapes.

The family tells me that the institution where Willie is now is unfit; and yet, in the last correspondence that I received tyey had the gall to ask me what type of a home does Willie have over at San Carlos, where he will be returning. I almost had the temptation to tell them that at one time in my life I lived in a home consisting of 12 children, not counting my mother and my father, where we had to eat off the floor, and the floor was made of Mother Earth—in other words, dirt.

I almost had the temptation also to tell them that while I was a student here at the University of Arizona, when I had a family consisting of my wife, a child and myself, because we could not afford any type of furniture we had to eat off the floor—I mean, like the floor that you are now sitting on—for 1 whole year.

It makes me angry when I recall this. But we are going to bring Willie back to his wife and the family, even if I have to just go over there and whisk him from that institution that he is residing in now.

These cases point out, I believe, Congressmen—and they are typical of all Indian reservations in Arizona—the need for on-reservation skilled nursing home care. Most of our elderly people are those who have spent most of their lives, if not all of their lives, on the reservation—the land they love. Why send them away from their homeland at a crucial time in their lives, their elderly years?

Those of you who are from Arizona and are now serving the Americans in general—I know you long for the time you can get back to Arizona—put yourselves in the shoes of our elderly people, like Millie over here, and appreciate why they want to stay on the reservation. But that just can't be done because of what you and I feel or because of the needs of our people. We have to have funding and the necessary facilities; and you indicated, Mr. Chairman, that there are only eight as of today.

You must understand that because of a decision, a landmark decision, in 1932, and because of the body of law that has evolved since that case, we, the Indian people, enjoyed a status that is probably equal to the 50 States that make up the United States.

We want to keep these reservations as they are today—if not add to them. These reservations are here today, and as a result the 50 States that make up the United States are here today.

Why do I say this? If you will look at what makes up an Indian person, you will see that he is the one who evolved from Mother Earth, because he was here even before there were people in bodies. He was here in the spirit. And he evolved. He is the one that has kept America from being invaded from foreigners. The only time where America came close to being overwhelmed by a foreign force was when the Philippines were attacked, and that was when—again because of the American Indian people—we stemmed them.

You will find within each Indian individual that he believes in the Great Spirit; he prays to the Great Spirit daily, perpetually. If it hadn't been for the American Indian, I think today we would probably be under a Communist regime.

Look back to the beginning and you will see that of all the groups throughout the world, there has been never an incident where an Indian tribe was annihilated by natural forces—floods, tornadoes, earthquakes. And you read about those things every day. Why? Because we believe in the Great Spirit.

And who taught us that? People like Millie Steel. And you have your own counterparts.

If we cannot provide enough resources to have our own skilled nursing home care type on reservations, then give us the funds so we can help a person like Gladys Steel Randall, the daughter of Millie here, so she can take care of her mother; and the same thing will also be done with other elderly people.

So you may ask: What is the future of America like? I would like to answer that question of yours, Congressmen, by telling you a story that involves a little boy, a guru, and a little bird.

You see, a guru is a person that has white hair, a long beard, a mustache that matches with the beard. And he usually sits on the floor, cross-legged; wears something white. And he represents intelligence, foresight, clairvoyance, and any other attributes that are along this line.

There was a little boy, as opposed to an elderly person, who always wanted to outdo the guru, to outwit him. But he never could, because the guru was always able to say, "OK, you are up to this now."

The little boy had a plan. He said,

> I am going to outwit the guru once and for all. The way I am going to do it is, I am going to walk up to him, put a little bird in my back like this, and I am going to ask him what do I have back here. Well, given his wisdom, clairvoyance, foresight and all that, he will probably say, "You have a little bird back there." And then I will ask him, "Is that little bird dead or alive?" If he says that little bird is dead, then I will show him the little bird and it will be alive. But if he says that that little bird is alive, then I will crush that little bird's head back here and I will show it to him, and it will be dead.

So the day came. He walked up to the guru, like this, and asked, "What do I have back here?" True to expectation, the guru said, "You have a little bird back there."

"Is that little bird dead or alive?" True to his wisdom, the guru said, "That is in your hands."

To answer your question as to what our future is like, Congressmen, I would like to borrow from the guru and tell you that is in your hands.

Thank you.

The CHAIRMAN. Thank you, Dr. Anderson.

The Chair now recognizes Ms. Elaine Quiver.

Ms. QUIVER. I am Elaine Quiver. I am a director of a Foster Grandparent Program. I would like to express my appreciation to be able to speak in regards to the impact on health and social services to the elderly.

At this time—I wasn't prepared for a lengthy speech or testimony for our tribe—but I do have a resolution that was submitted by the tribe, and I would like to take the pleasure of reading it to the audience.

Resolution Number 84-29XB, Resolution of the Oglala Sioux Tribal Executive Committee of the Oglala Sioux Tribe, an Unincorporated Tribe.

Resolution to submit recommendations to the House Select Committee on Aging.

Whereas, the Oglala Sioux elderly from Pine Ridge, South Dakota wish to avail themselves of the opportunity extended by the House Select Committee on Aging in expressing tribal needs and recommendations, and

Whereas, the Oglala Sioux elderly have long recognized the inadequacies and critical shortages of funds and facilities in trying to meet the overwhelming needs of its own elderly people: Now therefore be it

*Resolved*, That the following recommendations be submitted as a part of the record of the House Select Committee on Aging in the hope that these tribal appeals will be forwarded to all representatives of the Federal Government responsible for meeting these needs:

(1) In responding to the lack of sufficient swing beds, we request additional funds from the Federal Government for one skilled nursing facility. At present, we are deprived of a nursing home on the Pine Ridge Reservation for 150 Indian people who are placed in 5 different States. It costs more to have them transported to and from locations, when it could easily be avoided by having a nursing home built in the immediate area. Our elderly Indians are diminishing once removed from familiar environment. We need the support for more social, cultural and recreational activities.

(2) In our attempts to strengthen the emotional needs of our elderly, most of whom live in isolation and far removed from the benefits of family integration and community living, we strongly recommend having expansion of Federal funds for title VI, Foster Grandparent program and transportation on the Pine Ridge Reservation through Federal programs to enlighten the lives of the elderly.

(3) In providing for adequate health care for our elderly and in order to meet the standards of Medicare and Medicaid to all our first American elderly, we demand that added Federal dollars, staff facilities and equipment be provided for not less than 2 years for: (a) improved payment of claims; (b) administrative allowances; (c) adequate eye, dental, ear, and general care; (d) emergency medical needs; (e) community health representatives.

(4) We further appeal to the Select Committee on Aging that in carrying out all of our recommendations, we would like to be kept informed of the progress of the proposed changes to be adopted.

I have looked forward to this meeting on aging. Such meetings allow us tribal leaders to unify. In doing so, we will have a stronger voice in the administration and Congress.

I would like to thank the House committee for coming, again. Thank you.

The CHAIRMAN. Thank you very much.

The next witness is Roland E. Johnson.

Mr. Johnson, would you proceed.

Mr. JOHNSON. Thank you, Mr. Chairman, members of the committee.

My name is Roland Johnson. I currently serve as the chairman of the board of directors of the Laguna Rainbow Corp. This morning, I have the honor to represent the Governor of the Pueblo of Laguna.

It gives us great pleasure to be invited to discuss with you the concerns of our Laguna people regarding the services available to our elderly. Although I do not speak on behalf of our Indian elderly in New Mexico, I am sure that most will agree with the issues and statements I am presenting. I believe, as the spokesman for my community, that this hearing regarding the subject is long overdue, and I wish to take this opportunity to thank all of you for initiating and implementing this hearing.

We, in the Pueblo of Laguna, have long felt that our elderly represent the best and cherished values of the Laguna people. As late as the early 1970's, we began to develop plans to ensure that our elderly receive services that would enable them to live out the twilight of their lives in dignity and in a manner that reflects, concurrently, traditional, and progressive values. We have sought to incorporate these concepts into the programs we have developed on the Pueblo of Laguna. We have done this for the elderly by developing community-based services for our elderly and, at the same time, built an institutional facility to respond to the institutional needs of our elderly population.

There are 675 elderly age 60 and over in the Pueblo of Laguna. Of these, 5 percent are in the institutional setting. As our elderly grow even older, as the quality of our economic situation worsens, as more of our young seek employment off the reservation, and as our off-reservation Lagunas return to their communities—how then do we begin to meet these needs? Where do we find the resources necessary to implement services to meet both the minimal and necessary services that our elderly look to us as tribal leaders for? Especially when the Federal Government has become as dry with its financial participation as day-old fry bread?

We are at the crossroads, ladies and gentlemen, of creating a better tomorrow for our elderly people or creating a tomorrow without hope. This hearing is timely and it is needed. The Indian elderly of this country has grown by 71 percent between 1970 and 1980; or from approximately 64,000 to 109,000. By 1990, that population will double; and in doubling, the need for both institutional and community-based services will also double.

We need to begin now to identify those obstacles that impede the development at comprehensive and coordinated services for our Nation's elderly. We need not wait until the situation is at a crisis level to respond and explore new ideas. Our elderly do not have the luxury of time to wait—they didn't wait when they were our leaders to make decisions that benefited our respective communities. We, as leaders, and you as the moral and legal conscience of this country, cannot wait.

As I have indicated earlier, the hearing is timely and needed. Since the 1971 White House Conference on Aging, we have expressed these concerns. We express these concerns again; however, the sense of urgency with which we come before you today, underlines the critical nature of our concerns regarding these issues.

The Tribal Council of the Pueblo of Laguna applaud the commitment and the accomplishments of the Select Committee on Aging. Your foresight in identifying the Indian issue as worthy of a hearing is greatly appreciated and, I believe, presents a challenge to aging public policy. It is a challenge that will test our legal and moral resolve as a nation.

The executive director of our facility will later in this hearing expound in greater detail on our specific concerns and needs.

We, at the Pueblo of Laguna, stand ready to assist you in addressing these challenges. We thank you on behalf of our elderly for the opportunity to have this discussion. And let me further invite you to visit our community and get to know us. Without prejudice, I believe we are a friendly group to know.

Thank you.

The **Chairman**. Thank you, Mr. Johnson.

The Chair now recognizes Annie Wauneka.

Would you please proceed in any manner you may desire.

Ms. **Wauneka**. Thank you very much.

Good morning, ladies and gentlemen. I think I am very privileged to be here representing the Navajo Tribal Council.

Congressman McCain, Congressman Roybal, Congressman McNulty, there are three standards I will be talking about. The Navajo Nation, together with the Governors of the States of Utah, Arizona, and New Mexico, have worked hard and long over the years to create an atmosphere of trust and cooperation in developing agreements and contracts by which services could be provided to Navajos residing within each State.

Recently, the Navajo Nation hosted the Governors of all three States in recognition of the accomplishments thus far and to further establish a mutual agreement between each State and the Navajo Nation for future planning, problem solving, and negotiations. The positive response, and willingness of each State, has demonstrated their continuing commitment of support to the Navajo Nation, a willingness to meet their responsibilities to all residents of their respective States.

This attitude of responsibility must be further demonstrated by the Federal Government, not only to individual States but to the Navajo Nation through its Federal trust responsibility and treaty obligations. Due to our unique service area, the Navajo Nation programs must deal with compliance issues that are not experienced by most service populations.

Various Federal, State, and tribal funds are used to provide aging services and programs. Federal regulations often conflict in terms of eligibility which is then further compounded by the three individual State income and eligibility standards. Depending on where you reside with the Navajo Nation, you may or may not be eligible for the same service as another person living directly across the State line. This impacts most heavily on the elderly.

The Navajo Nation has stated in previous public hearings that this problem needs to be addressed. However, the purpose of mentioning this issue is to draw attention to the enormous problem encountered with the three State standards in addition to the Federal requirements of each funding source.

To cite an example, if a client receives supplemental security income, in all probability they will be considered ineligible for services provided under Public Law 93-638, the Indian Self-Determination Act. However, if a client receives SSI, they are eligible for supplemental State health care and other services. In addition, if a client receives SSI under ACTION, the Federal volunteer agency, no client income criteria is necessary.

Title VI of the Older Americans Act, direct funding to Indian tribes, provides nutrition, transportation, legal and other social support services to the elderly as does title III of the same act. The act stipulates that a combination of title III and title VI funds is prohibited. The current level of title VI funding is not sufficient to equal the level of title III funds allocated to Indian tribes.

Therefore, many tribes receive two sources of funds from the same act to provide the same services, but which in no way can be combined. Also, title VI is directly from the Federal agency while title III comes through the added regional and State systems.

The conflicting requirements, criteria and standards with which elderly of the Navajo Nation must contend simply to receive needed services only serves to add to their high risk condition, and results in an unnecessary lack of response to a tremendous human need.

Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1977, is understood by the Navajo Nation, through the Navajo Tribal Council, as intended for tribes to prioritize, develop, and administer programs and services.

In October 1981, the Navajo Nation contracted the BIA Social Services through Public Law 93-638. It was felt that the Navajo Nation and the Navajo area BIA would join in a unified effort to insure that Navajo people received the much-needed services that were available within the intent of the act and that adequate appropriations would be provided to meet the documented need. Instead, the Navajo area BIA applied their expertise to enforce the letter of the law rather than utilize the regulations as a tool with which to implement the services.

Their main focus was to monitor the Navajo Nation. Whereas, the regulations within the 25 CFR could have been the means to further meet the needs of the people, it became the "club" with which to impose inflexible demands based on the narrow interpretation of the law. The Navajo area held the Navajo Nation accountable in a manner that even they, the bureau, had never been subjected to.

When the Navajo Nation took over BIA Social Services in October 1981, hundreds of pending cases and applications remained unassessed. BIA's justification was that the tribe would be assuming the social services contract.

Of those elderly clients that were assessed by BIA, the majority remained unserved and funding projections turned in by the Navajo area BIA remained grossly inaccurate since they were based on service levels and statistics which were not inclusive of numerous clients unassessed beyond 45 days, unassessed due to anticipation of the Navajo Tribe assuming the BIA Social Services operation, and unassessed due to conflicting procedures and requirements.

Certification of clients was resumed once the contract was transferred to the Navajo Nation, utilizing the procedure established previously under the BIA. Within a year of the tribal contract, under the scrutiny of the BIA, the Navajo Nation was instructed to apply State income standards in a manner which resulted in approximately 300 elderly clients being determined ineligible within a 6-month period. Many of the clients had been previously certified and/or recertified as eligible for services under Public Law 93-638 by the BIA for the past several years. The interpretation by this Federal agency has turned the dream of self-determination into a nightmare for clients.

A national Indian aging policy was expected to be drafted by the Administration on Aging in 1982. Although public hearings and written testimony have been continually provided to expedite the development of a policy from the Navajo Tribe and other tribes throughout the Nation, no policy has been forthcoming.

This delay in drafting and implementing a policy has resulted in numerous Indian tribes and organizations being underfunded or not funded at all, although their elderly population has continually increased and the needs of the elderly have continued to magnify during the delay in developing a policy.

Although the Federal Government, through the Administration on Aging, has been responsible for the 2-year delay, the Navajo Tribe, through Navajo Tribal Chairman Peterson Zah, has identified three major tribal policy areas to be developed and implemented in the immediate future. These are: One, provide adequate health, nutrition, transportation and housing assistance for senior citizens; two, establish advisory committees to encourage the participation of our senior citizens in the tribal government; and three, involve Navajo senior citizens in the cultural education of our youth.

It is demonstrated through the development of these policy areas, as well as a yearly tribal appropriation of approximately $25 million for direct services, that the Navajo Tribe puts a very high priority on the well-being of the elderly members of the tribe. In turn, we request that the Federal Government uphold their trust responsibility to the Indian people by putting a priority on our elderly tribal members as well, through immediately developing a national Indian aging policy with tribes and Indian organizations, and subsequently requesting adequate appropriations from Congress to implement the policy throughout the Nation.

To assist in the accomplishment of this goal, the Navajo Nation will continue to call upon the congressional leadership and Governors of the three States of New Mexico, Utah, and Arizona, to support and assist in the development of a national Indian aging policy cooperatively with all tribes and Indian organizations.

The Navajo Nation wants a culturally conducive policy that will truly impact on the lives of our elderly, a policy designed from a tribal viewpoint rather than a Federal viewpoint. That policy must prioritize the needs of the elderly over the concern to save the Federal dollar. It is very important that this policy become a reality this year—not next year, or 2 or 3 years from now.

The knowledge, wisdom, and identity we lose as Indian people with the passing of the traditional Navajo elderly is too precious and valuable to let us allow this delay to continue. As Indian tribes and organizations, we must make a comprehensive effort to see that our elderly are well cared for and protected in the immediate future, not only for their total well-being, but for our cultural identity and survival as Indian nations in this country.

Based on the three areas of concern I have expressed—one, three State standards; two, self-determination versus Federal regulations; and three, the development of a national Indian aging policy—the overall recommendations of the Navajo Nation to this oversight hearing are as follows:

One, $50 million be appropriated for title VI of the Older Americans Act from Congress;

Two, an Indian desk be established at the Administration on Aging to be filled by a qualified Indian aging professional;

Three, $30 million be appropriated for title V of the Older Americans Act through direct funding from Congress;

Four, a comprehensive 3-year budget and proposal be approved by the BIA for Indian aging programs established under the Indian Self-Determination Act, and a subsequent request be made by BIA to Congress for adequate appropriations;

Five, the Senate and House Select Committees on Aging request monthly update on the progress of an Indian aging policy from the Commissioner on Aging until such time the policy is developed; and

Six, per President Reagan's statement last January 1983, government-to-government relations between the Federal Government and recognized Indian tribes be stressed and prioritized in funding and policy development areas in relation to aging programs and services.

The Congress of the United States has invested in the elderly to uplift their daily lives, and for this we are appreciative. Thank you for this opportunity to make the concerns and recommendations of the Navajo Nation known through this hearing.

Thank you very much.

The CHAIRMAN. Thank you.

The Chair now recognizes Mr. Ray Olney.

Mr. OLNEY. Good morning, Mr. Chairman and members of both committees. My name is Ray Olney. I am an enrolled member of the Yakima Tribe in the State of Washington. I am a member of the Yakima Tribal Council. I am delegated as a witness representing the Yakima Tribe.

Our tribe is a federally recognized tribe established by treaty in 1855. On behalf of the tribe, I would like to thank both committees for the opportunity to present testimony on issues that impact our Indian elders.

Because of the critical role that the older tribal members play in the day-to-day life of the Yakima Indian Nation, we are extremely concerned with providing the best and most effective services to each and every one of them.

Unfortunately, our goal of providing these critically needed services has been severely inhibited by a total lack of coordination on the part of various Federal agencies, unclear and cumbersome Federal regulations, and a severe shortage of funds.

In the fiscal year 1983, the Yakima Nation's area agency on aging received its funding from four predominant sources, primarily title VI, title III of the Older Americans Act, State funds provided under a State statute and contributing also was the tribe.

The title III funds are utilized by an on-reservation elderly nutrition program. This program allows us to distribute hot meals to a limited number of elderly members who cannot leave their homes for various medical reasons.

It is also utilized to provide a centralized lunch program for older tribal members who come to have a hot meal.

Because of the size of our reservation and the Federal regulations which require us to service all Indian and non-Indian citizens living within the boundary of the reservation, I think a key factor is that we presently, on our reservation, have a ratio of 3 to 1 who are non-Indians who live on the reservation or within the exterior boundaries of the reservation.

Then under the title III funding, it is also used to provide an equally critical service, that of outreach assistance. And because of the older people not being educated, they have extreme difficulty completing forms for such services as Social Security, food stamps, and Medicare; and to make matters worse, the closest service office on the reservation is an average of 20 to 25 miles for the elderly. So consequently, the outreach program through our elderly program is a major factor in our elderlies participating in the other federally funded programs.

I feel it is important to take a moment to discuss the unique and often severe problems which many of our older people face, and this primarily is in the certification area for eligibility for services in the health or lack of health related areas that they are confronted with, and then the income level criteria that they are also confronted with.

Despite these proven facts, Federal regulations make no attempt to take them into consideration when allocating funds to Indian aging programs, and we feel that this is wrong.

I think of major importance also is due to the budget cuts, a serious problem has been created in the health support area. First, the Yakima Indian Nation has been using the remainder of our State-funded dollars under the State Senior Citizens Service Act to purchase health appliances, such as glasses, dentures, hearing aids, et cetera, for those individuals who could not receive social assistance from Indian Health Service funds.

In the Portland area, Washington, Oregon, and Idaho, that is the only area within Indian Health Service areas that does not have an Indian Health Service referral hospital. So consequently, we function extensively on contract care funds for referral systems.

So we have literally been put in a situation where we have to prioritize who is going to receive the service. And when you come to hearing aids, glasses, and these types of incidentals, they are put on the bottom of medical priorities and this includes those who are senior citizens.

The Indian Health Service in the Portland area does not provide special programs that target the Indian elders. Older Indians are included in all health and social services that are provided for all other segments of the population.

On the issue of joint agreements or cooperative health projects between Federal agencies, an agreement between the Health Services Administration, of which Indian Health Services is a part, and the Administration on Aging was entered into early in 1979, and covered the fiscal years of 1979, 1980, and 1981. One result of the agreement was the funding of the Yakima Home Health Care Program, one of three Indian programs funded nationwide. The agreement was conditional and dependent on the continuing availability of funds.

The Yakima Tribe provided home health services that demonstrated effectiveness in treating and caring for the frail and chornically impaired older Indian people. After proof had been delivered that such activities are critical to the well-being of our elders, and after creating a dependency for such treatment and care, project support was discontinued by all Federal agencies with no future year considerations.

That has been our experience with interagency agreements on health services for Indian elders.

The Bureau of Indian Affairs at the Yakima agency acknowledges its general long-term care responsibilities to Indian elders, but offers no special set-aside or programs except HIP grants or separate home programs.

I will not go into the need for extended care facilities for the Indian elders on the Yakima Reservation since I expect that such testimony will be presented repeatedly here today. Let's suffice it to say that the need exists the same on my reservation as it does anywhere else in Indian country.

In conclusion, I would like to assure all concerned that the Yakima Indian Nation is willing at any time to work with any group or agency in the effort to enhance the quality of life for Indian elders while preserving their pride and rich culture.

Thank you again, Mr. Chairman, for the opportunity to testify today.

Thank you.

The CHAIRMAN. Thank you, Mr. Olney.

I would, first of all, like to thank the panel for providing very interesting testimony.

May I, in sum, restate that the need is there. The statements just confirm a situation that we have known to be in existence for a long time. But for many others the statements may be revealing.

We were told that the Indian community would prefer to spend their elderly years—if they have to be in a home—in a home in their own community. We are told that in the White House Conference, the Indian communities did, in fact, participate and make recommendations, but those recommendations have not been implemented.

We were also told, while there may be an established mutual agreement between the States and the Navajo Nation for future planning, for problem solving, and for negotiations, that the Federal Government somewhere down the line has not been a participant in that agreement. This clearly points out the lack of compassion and interest on the part of the Federal Government.

You pointed out, I think very clearly, the defects that we have had—for example, the conflict we have had in the application of titles III and V. Now, that ultimately results in complications.

You made the recommendation that a national Indian policy be established, and you told us why. But you also told us that there had been budget cuts and that those budget cuts have in fact been injurious to any program that might have been developed.

The truth of the matter is that a really sincere program has not been developed to assist the Indian community throughout the United States. As chairman of the committee, I must acknowledge that, because I believe that to be a fact.

But you pointed out in your discussions—in the resolution, for example, that was presented, and in the recommendations—that there are certain things that have to be done. We, for example, on the Committee on Aging, have tried for a long time—and continue to send letters and make recommendations, doing everything we possibly can—to establish an Indian desk. We are constantly told that that can't be done, because if we do that we have to do it for other groups.

But I think that is an excuse, because the matter of treatment and negotiations between the Indian nations took place way before there was any particular conflict between the ethnic groups in the United States. It seems to me there is a precedent that has already been set; that that excuse is not sufficient.

But there is again the matter of funding. The cutbacks that have taken place in the last 2 or 3 years have been tremendous: cutbacks in education, in health, in Social Security, and in Medicare. They have been so tremendous that everyone seems to have suffered. But, in my opinion, the Indian community has suffered even more than anyone else.

What I am getting at is that I would like to take back something to my overall committee. Would it be possible for this panel to get together and, in 1 hour, for example, go over the recommendations of each and every one of you, and present it as a recommendation of the panel itself? If that is possible, I would like to take those recommendations back.

For example, I think we can recommend together that an Indian desk be established. And I think that you can recommend together that more be done to coordinate the activities of existing agencies to provide services. And you can also agree together, I believe, that the need is so great that we must expand the facilities of the various Indian tribes as they now exist.

For example—I would like to question Dr. Anderson—how large is the facility at San Carlos?

Mr. Anderson. It is $296,000, and it can hold only about 10.

The Chairman. Now, here is a facility, for example, on an Indian reservation that can only hold 10.

How big a facility is needed—250? 350? What is the number of people that could be accommodated, if you had a facility?

Mr. Anderson. I think counting people like, for example, Mr. Steel, who has been confined to an off-reservation institution for 35 years, we would like to have a facility that can hold approximately 300.

We have a population on the reservation—a total of approximately 9,000.

The Chairman. A population of 9,000 in the State of Arizona.

I understand there are facilities to accommodate the needs of 450, which means that the facilities at the present time are almost nonexistent; that there are some facilities, but definitely not enough.

I was wondering if each one of the tribes can make a recommendation to me some time today telling me you have a facility that will take care of so many but you need so many; and then let us see if together we cannot form a little team that might carry the message to the Federal Government.

I am also on the Committee on Appropriations. I think I am the only member of the Committee on Aging that also sits on the Committee on Appropriations. I have been responsible for the funding of various programs for the Indian community, but not enough. What I am saying is, I would like to work together with this panel to do more.

The Chair will now recognize Mr. McNulty.

Mr. ANDERSON. Mr. Chairman, if I may respond.

I would also like to add that when several tribes were elected for demonstration homes, we were not even on the list, and I had to go to Washington to get us, the San Carlos Tribe, on the list. And that is why we were able to get this home that can hold 10 elderly people. Otherwise, we would not have any.

The CHAIRMAN. You know, Dr. Anderson, several years ago I brought to the Committee on Appropriations the matter of congregate housing and provided the first $15 million for that purpose. At that time, it was considered a demonstration project. Congregate housing today is big business, and it is still considered a demonstration.

Well, how long is it going to remain in the demonstration stage? I think the need has already been demonstrated. We don't have to demonstrate any more, make any more studies. We have enough facts now to go out and go to work.

Mr. ANDERSON. I want you to understand we are still demonstrating.

The CHAIRMAN. Mr. McNulty.

Mr. MCNULTY. Mr. Chairman, members of the panel, I know several of you from previous testimony. I know that you are intelligent and sophisticated enough not to need much by way of urging from me. I don't want to be in a position of giving you political advice. But I hope you will listen very carefully to what the chairman just said. And if that isn't an opportunity to be jumped on, and quickly, I never heard one.

Thank you.

The CHAIRMAN. Mr. McCain.

Mr. MCCAIN. Thank you, Mr. Chairman.

I would like to thank all of the panel members for being here. Some have come a long way to appear at this hearing.

I also would like to recognize that Dr. Anderson speaks not only for himself but also speaks as president of the Inter-Tribal Council of Arizona.

I would be remiss not to especially recognize Dr. Wauneka, who has become a legend in Arizona for the many contributions she has provided.

I also concur with the comments of the chairman concerning the lack of funding. Before I go into that a little bit—there is a Senate amendment—part of the amendments for the reauthorization of the Older Americans Act, to place a Special Assistant for Indian Affairs in the Office of Aging. And I hope that we on the House side will propose a similar amendment and will put it in on our side.

I would like to go back a little bit to my original statement, and I would appreciate a comment from the members of the panel. I hear a recurring theme that there is a lack of coordination of these scarce resources: Title III money, title VI money, BIA money, aging funds. There appears to be little or no coordinated effort to devote those funds where most needed.

I would appreciate comments or recommendations as to how we might be able to solve that very difficult problem. Let's start with you, Dr. Anderson.

Mr. **Anderson**. On what issue?

Mr. **McCain**. The lack of coordination of the various programs and moneys that are available.

Mr. **Anderson**. We have to sort of go back to the point that I made earlier that has to do with the government-to-government relationship between the tribes and the Federal Government. Some programs that are not funded on the reservation are funneled through the State. But even there, when it comes to allocating the funds, we have to compete with other interest groups, political groups and concerns.

So the main thing that I am stressing I think to take care of the coordination part is to direct the funds to the tribes, because you have to understand that they are sovereign nations, and this is something that has been recognized by courts; is still being recognized. We would like to some time come to a point where that is a given.

I think we are in a day and age when we see articles, writings and whatnot—for example, in Outdoor Life, the last two issues have contained writings that indicate that there are voices within the United States interested in doing away with Indian reservations.

I think we ought to get to a point some time where we, the Indian tribes, should not have to worry about fighting to keep the land that we have left. I think we ought to understand that at one time we owned this whole continent. It was 1492 when Columbus happened to come by this continent and he discovered us, the Native Americans. He discovered that we were here. So he didn't discover America; he discovered that there were native people here on this land.

I think all we have to do is appreciate that there is a tribal government and you are going to have to accept the fact that there is a government which has been in place from time immemorial. In 1932, we had the landmark case—came up with the aboriginal concept. We are going to have to accept that. And I think it ought to be accepted as a matter of course by now, so that whenever any person comes up and says, "There are these tribal groups on Indian reservations and, because they keep in harmony with nature, they have not developed their resources—we, who are on the outside and need those resources, water and minerals, forests, whatever, we ought to do away with the reservation so we can go in there and exploit them. There are those that say that, and this is when we need you.

I think we ought to establish once and for all that there are these Federal enclaves, because that is the way we are recognized; and they are going to be there forever.

As far as my reservation is concerned, our reservation was established in 1972, but there is a treaty which was enacted between the U.S. Government and my tribe in 1852, and that occurred before there was a Gadsden purchase. And, you know, Arizona is one of the States that became a member of the Union. And why? Because we, the Indian people, agreed that if they would not have any jurisdiction over our land, then they can become a member of the Union. And there is that clause in the Arizona Constitution. It is also in their statutes. And yet, we still have people that try to assume jurisdiction, if not do away with our tribal sovereignty altogether.

So, coming back to your question about coordination, coordination is not the problem. The problem is that you recognize as a government which is on equal par, if not higher, than a State government, and we have the Governor of the State of Arizona who recognizes tribal sovereignty. Unfortunately, we have an Arizona attorney general who has other aspirations, and because of that he wants to take over all the Indian lands in Arizona.

Mr. McCAIN. Thank you, Dr. Anderson. Time is very short.

I want to assure you again—and I am sure the chairman will agree—there is no serious movement on the part of Congress or the administration to go through the disastrous experiment of the 1950's. Congress and both Democratic and Republican administrations since have made that very clear.

Very briefly, would any other panel members wish to comment?

If not, thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The Chair would like to thank the members of the panel for very excellent testimony and would just like to make one point; that is, the Chair sees that in the Older Americans Act that is now before the Congress that there is language in title VI that deals with granting certain grants for Indian tribes, and that that language is not in the House version so far.

We would appreciate letters, telegrams, and phone calls to Members of the House to see that that language is put in. I will look into that subject matter together with the members that are here, and we will see how we can best accommodate language in title VI that will include grants for Indians.

Thank you again.

I would like to have the next panel come forward. The panel will be made up of Robert Lewis, Pauline Tyndall, and Kay Jewett.

Before hearing from the second panel, I would like to call on Francisco Jose, Jr., chairman of the Papago Tribe, to present a statement from Senator DeConcini. Senator DeConcini regrets that he cannot be here.

You may proceed in any manner you may desire.

[Prepared statement of Hon. Dennis DeConcini may be found in the appendix.]

## STATEMENT OF HON. DENNIS DeCONCINI, A U.S. SENATOR FROM THE STATE OF ARIZONA; PRESENTED BY FRANCISCO JOSE, JR., VICE CHAIRMAN, PAPAGO TRIBE

Mr. JOSE. Honorable Congressmen, I am very honored today to read a statement of Senator Dennis DeConcini.

I regret that prior commitments prevent me from joining the chairmen and members of this distinguished panel here today. However, I do thank both the Aging and the Interior and Insular Affairs Committee chairmen for coming to Arizona to hear about the health care needs of Indian elderly from the tribes and the elderly themselves. The power and prestige of your committees will be critical to any congressional action necessary to address the numerous concerns presented today.

Your findings will certainly be invaluable to efforts in the Senate where I, with a number of my colleagues, am pressing for the timely development of a long-needed national policy on Indian aging. In fact, I have asked that the Senate Select Committee on Indian Affairs hold joint hearings with the Senate Special Committee on

Aging and the Aging Subcommittee of the Labor and Human Resources Committee on Indian aging policy issues in the very near future.

My experience in working on Indian aging matters has taught me that native American elderly know what their policy and service needs are. So I am sure that you will not leave Tucson without receiving the full benefit of their views and recommendations, Theirs is a perspective which should guide all who make the policy and provide the services on which the elderly depend to enjoy a better quality of life.

Thank you for the opportunity to express my support and appreciation for your efforts on behalf of the Indian elderly.

I would like now to make a brief statement on behalf of the Papago Tribe, of which I am vice chairman.

We refer to our elderly as the wise ones. They are the most important members of the Papago community. They are the link or the catalyst for the strengthening and the survival of the Papago tradition and culture. They are necessary for the fulfillment of the tribe.

The past 10 years, the Papago Nation has attempted to obtain funds to construct a much-needed nursing home where our wise ones will receive sensitive health care and social services in familiar surroundings close to home, family, and friends. We recommend that funds for construction be increased and funds for home health care, also. We would like to recommend that because of the partial funding from the BIA for custodial and funding from the IHS on skilled nursing—as you have heard, it is difficult to coordinate, because it is difficult to get a realistic figure of the amount of funding in those particular areas. Now, with the difficulty of coordination, it is hard for our two tribes to plan for the future of our elderly people.

These are just some brief statements I would like to make on behalf of our tribes. Thank you very much for this time.

The CHAIRMAN. Thank you.

The chairman will now recognize Ms. Garreau. Will you please proceed?

[Additional materials submitted for the hearing record from Pauline Tyndall and Howard McKinley, Sr., may be found in the appendix.]

## PANEL CONSISTING OF KAY JEWETT, CHEYENNE RIVER SIOUX TRIBE, EAGLE BUTTE, SD; PAULINE TYNDALL, EXECUTIVE DIRECTOR, CARL T. CURTIS HEALTH EDUCATION CENTER, THE OMAHA TRIBE OF NEBRASKA; ROBERT LEWIS, DIRECTOR OF COMMUNITY SERVICES, PIMA-MARICOPA INDIAN COMMUNITY; AND HOWARD McKINLEY, SR., THE NAVAJO NATION

Ms. JEWETT. My name is Kay Jewett.

The Cheyenne Tribe clearly recognizes the need for improved health care for our elderly. Presently, we have no long-term health care facilities on our reservation whatsoever. The tribe is providing to the best of its ability health care measures to assure that these people will stay in their homes as long as possible. However, as sad as it makes everyone, there will come a time when our grandmothers and grandfathers will have to be placed in a skilled health care facility.

As of right now, we are sending them off the reservation. And all too frequently, due to the low economic level, families and friends are not able to visit them; they are not able to monitor the care that they are given.

There is no cultural consideration taken; they are lumped together. What we are finding is that they are left to live out their last years in loneliness, isolation, bereft of family and culture.

What we are asking is that funds be made available to provide this desperately needed service to our elderly in order to enable these people to live out their last days in dignity.

We thank you for the time that you have given us to be heard. We would appreciate any help that we can get.

The CHAIRMAN. Thank you.

The Chair now recognizes Ms. Tyndall.

Ms. TYNDALL. Thank you.

Mr. Chairman and members of the two committees, I am here today to present information on the need for long-term care facilities for our elderly American Indian population. Statistics show that in United States, the lifespan has increased for the elderly. This is true for the American Indian. In the past decade, our lifespan has increased to 71 years. In comparison with United States all races, we have not yet attained that level that they are enjoying. Infant mortality is lower, birth rates increased, which tells us long-term care demands will increase over the next several decades.

There are many factors to consider in determining health needs of our Indian elderly. The socioeconomic conditions on the reservation contribute to a greater need for special services to the elderly in the area of long-term care.

We have a population of 300 over 60 years of age, many of them reaching a point of no longer being able to live alone. The fact that we do have abused elders, who need our consideration, protection and care, is very real.

The Omaha Tribe owns a 25-bed long-term care facility, built under an EDA grant. It is operated under a Public Law 93-638 contract with Indian Health Service. In 1977, a congressional add-on provided funds for the staffing and operation of this facility which included the nursing home and an ambulatory care unit for an outpatient clinic for the tribe.

Indian Health Service took the stand that they were not in the nursing home business, but since the funds and facility were in place they would have to be. This has been their stance. There is no consideration to our facility as a health delivery resource, important in the total health of Indian people. Nor has technical assistance been available or additional funds since 1977. The Bureau of Indian Affairs has no contact or liaison in any manner with this service.

To offset this gap, we do utilize third-party funds from Medicaid. Our statistics of utilization have no place in the reporting system of Indian Health Service; consequently, our occupancy rate is not considered, with number of in-patient days of care provided in a true cost analysis. There are positive factors to our operation wherein the local Indian Health Service hospital and the Aberdeen area office do work in harmony with our facility within the realm of available resources.

As a care unit, we provide all of the required services for rehabilitation. We are now forced to provide skilled care and are waiting for our State survey and certification. This will enable us to provide a more acceptable level of care, as our elderly—and their families—do not like to have patients transferred to another facility.

An unmet need exists in the area of long-term care for Indian elderly both in the skilled and intermediate care levels. This is evidenced by the small number—eight—of existing long-term care facilities providing care to Indian residents. We consistently receive requests for admission from urban centers and other States, which we cannot fill.

The tribally owned and operated facilities are operated in a manner pleasing and acceptable to our elderly. Their cultural needs can be met in unique ways as well as emotional and physical. Many times, residents are transferred to our facility from off-reservation facilities, so sedated they are more dead than alive. It takes us weeks to bring them out of this and adjust to less medical restraints.

We are in position to expand our services. The tribe owns the facility and apparently no resources exist to allow expansion. Priority for facility construction does not exist in construction funds of IHS. If our health care system is to become solvent, we need to be able to provide services to more residents at increased levels of care.

If tribes are to operate long-term care facilities—and we should—there must be adequate support in obtaining facility resources. There must be funds available to expand facilities to be able to generate income with the potential to become self-sufficient through generated income.

Long-term care is a health need largely unfulfilled by the Indian Health Service. We should note the trends of health care today, that health care delivery of the future will be in the long-term care, intermediate, skilled and habilitive, and the ambulatory settings.

I think the comment was made this is very revealing testimony, and that actually we didn't need to reveal this need; that it was known. But I think it was revealing to me today because I had—and this is a sort of emotional thing—it was a very beautiful experience, to me. I was in Oklahoma at the Army fort there, the old Fort Sill, and we were touring the reserve and were taken to the cemetery where Geronimo's band is buried. He is buried somewhere else on the fort.

Sitting here today and hearing the Apache Nation pleading for help in bringing one of the very elderly people off the reservation here, it occurred to me that this has been going on for decades; that those people in the cemetery on the Army reserve at old Fort Sill in Oklahoma died from various causes; they probably died untimely deaths far away from home. They are buried in a serene, peaceful spot.

But it makes you wonder why they are still in a position of having to come forth and beg to be brought to our homelands.

Thank you.

The CHAIRMAN. Thank you very much.

We now recognize Mr. Robert Lewis.

Mr. LEWIS. Chairman Roybal, Congressmen McCain, and McNulty, I am Robert Lewis, director of community services for the Pima/Maricopa Indian Community. I would like to reemphasize some of the points that have already been made, from the perspective of a tribal program administrator, those of us who deal with the nuts and bolts of providing services to the elderly of our Indian communities.

I think that many of the points that have been raised will be repeated throughout this testimony, but the concern I would like to bring to your attention, from my perspective, is the major recurrences of Federal funding for long-term care services. It is a problem. I would like to point that out a little bit more specifically.

First of all, I think we need to appreciate the fact that tribal services in the areas of human needs are relatively new, many beginning from the time of the Indian Self-Determination Act less than 10 years ago. And I think that is a consideration known by Members of the Congress.

A great deal of progress has been made in that time as Indians have become self-determined, moved toward self-reliance. Most important of all are the willingness to assume responsibilities for the care of their elderly and their citizens. I think that is an important point to be made. We are all here as a witness to that commitment.

I think that the fragmented nature and coordination we talk about is a serious problem, because as we all know the funding is inadequate. But the fact is that it would seem that some way could be put into the law where these could be at least effectively put out in a distribution system that is much more equitable than it is right now.

We realize that changes in the legal structure of these laws is going to be an involved process. But I believe that it can be done.

You have heard testimony regarding title III and title VI, which we must use in concert to even provide minimum services as far as the in-home and community-based services are concerned. In the relatively small program that we administer in our program, we have to patch together title VI, title III, and title XX, each with different funding years, each with different policies, each with different administrative requirements, which puts a tremendous burden on tribal structures that are already limited, and resources for the management of services. I think that is an important point.

The funding levels that are provided provide very little in the way of ability to manage them effectively. Most of these funds must go directly into services. This is a serious handicap for the tribes.

Realizing that funds are limited, it would seem that more efficient use of these funding mechanisms—the older Americans, aging moneys, and others that are relevant—could somehow be put into at least one pot for one comprehensive program on the reservation.

I believe that titles III and VI, the real key I think to making those more responsive, the moneys from those programs, was pointed out by Dr. Anderson. Those funding sources do not actually recognize tribes in the distribution of their funds.

I think if that somehow could be put into the law, there might not even be a need for title VI. Title VI is essentially part of the same initiative. There could be one title which includes and recognizes Indian tribal governments for what they are, and that is governing bodies which have needs that—they must serve the need of their constituencies with services, as any other sovereign government. I believe this would resolve some of the difficulties that we encounter in working with these separate agencies with their separate mechanisms.

That, I believe, is a key point. And until the Congress begins to recognize tribal governments for what they are, we will continue to have difficulties with these funding sources.

I think that the matter of coordination and effective service delivery is a concern that we all share. We realize the limited resources available to us. But we are willing, as tribes, to make the most effective use of these moneys in concert with the various funding agencies of the Federal Government.

Our only wish is that we be included in the planning, the development of policies and laws that govern the release of these moneys.

With that, I would conclude my statement. Thank you.

The CHAIRMAN. Thank you, Mr. Lewis.

The Chair recognizes Mr. McKinley.

Will you proceed, sir.

Mr. MCKINLEY. Honorable Congressman and members of the committee, I am one of the oldest in terms of years, but I only have a minute, I understand, to testify. My name is Howard McKinley, Sr., of the Navajo Nation. This is my consumer testimony, and these are my prioritized consumer concerns for long-term care: One, adequate, culturally conducive housing; and two, dependable transportation.

In order to secure Federal funding to meet the basic needs of the Indian elderly, it is mandatory and urgent that we unite all our efforts including the tribe, State, and Federal Governments. We need immediate attention to clarify conflicting Federal regulations and develop an Indian aging policy. In addition, a very clear definition of self-determination from a tribal viewpoint must be enforced.

A happy home is the focal point for many existing services and programs, such as transportation, nutrition, health, and social services to allow the elderly the independence to stay within their own environment. Simply stated, as expressed in the old song, "Be it ever so humble, there is no place like home, sweet home."

On behalf of the Navajo Nation, I present these important concerns and make known for the record that the Navajo Aging Services will present additional written testimony within 20 days of this hearing.

Thank you.

The CHAIRMAN. Thank you, Mr. McKinley.

I would like to acknowledge my appreciation of the recommendations made by this panel. I am going to quickly point out some of them.

I think there is unity in the recommendation that has been made with regard to long-term care. I think we agree that long-term care has gone unfulfilled, and a great deal more has to be done to bring about a better atmosphere with regard to long-term care, particularly long-term care on the reservation itself.

A further recommendation was made with regard to the distribution system needing to be improved, and with that we wholeheartedly agree; and the recommendation by Mr. Lewis that there should be a consolidation of titles III and VI.

Mr. McKinley, I think, one of the recommendations that caught my attention more than anything else was the fact that, due to his wisdom, having lived many years, he is recommending that there be a united effort of all tribes to present a united program for program changes, for the equitable distribution of funds, so that these facilities can be achieved.

Now, taking that very brief summary, I would like to ask some brief questions, and anyone on the panel can answer.

One is: In this discussion this morning, we were told the Indian community would rather have their senior citizens or elderly at home and take care of them at home. There comes a time when it is necessary to place them in a long-term care facility. But what can the Federal Government do, for example, to assist those individuals who do in fact care for their elderly at home?

Mr. Lewis, you being the social worker, which is a background that I have, perhaps we can start by asking you what can we do with regard to that particular problem.

Mr. LEWIS. I think that attention should be focused on these emerging needs. I think what has already been stated is a development, I think, of a more specific definitive policy regarding the elderly in general and Indians specifically. Until we have an agreed upon policy from which we can emanate programs or whatever services that meet these needs, we are going to be moving about in an uncharted way.

I would suggest, along with others, that we begin to understand long-term care as a continuum of services that begin with the informal efforts of families down through the various levels of care, which would be home-based service, community-based services, and finally, ultimately, the skilled nursing care at the other end of the continuum. I think until we define these policies that must come from the Government in terms of funding, since it is very obvious we are going to be dependent to a certain extent on federal funds, it is going to be hard to focus on it.

So I would see beginning to define a definitive policy that all agencies and programs be related to, would be the start before we can begin to become more effective immediately; that we are just coming to recognize in a formal manner.

The CHAIRMAN. Mr. Lewis, you have recommended that certain changes are necessary, and you said consolidation of titles III and VI.

How will the Indian community be affected directly if we were to consolidate titles III and VI?

Mr. LEWIS. I think we could provide more effective services, certainly more comprehensive services, to the level of need. We are restrained by what we have available to us. And our tribe, and many other tribes, do contribute to the services that are in the program.

The sad fact is that most tribes are limited in their own resources. But our tribe, within its limits, does also act. So we have a four-part funded program.

I think that goes back to the same argument that I think we put forth before. I think we do have the ability to design the programs according to the needs of our community. I think what we need is the flexibility to do this.

As you know, there are many constraints built into the various funding agencies that we have. So many times programs are not geared to the needs that we want to get at, but they are geared to the needs of the funding agencies. And sometimes we have to strike compromises to deliver basic services.

Until we have that flexibility, I think we are going to be hampered in the initiative to provide services which we know we can do.

The CHAIRMAN. Ms. Tyndall, do you agree about the consolidation of titles III and VI; or should we go even beyond that consolidation, maybe even establish within that title or any other title a department that concerns itself with the problems of Indian affairs?

Ms. TYNDALL. I would like to see consolidation of services. But I do believe it has to be also delivered in a consolidated manner, which would be a department. And I think it has to cover many spectrums of need that may not be addressed in title VI and the other titles.

Take, for instance, Hill-Burton moneys were made available for various kinds of hospital settings. Indian Health Service or the Indian people have not had that kind of opportunity. And we are not going to be able to give long-term care need unless we have direct funding to build facilities.

The CHAIRMAN. The Chair now recognizes Mr. McNulty.

Mr. MCNULTY. Thank you, Mr. Chairman.

Mr. Lewis, the Indian health care legislation that we are working on now would provide tribal specific health plans. I want to know if you are familiar with that fact, and whether or not you think the tribes will take advantage of that and maybe try and crank in some specifics for their own tribe to entitle them to some allocation of funding.

Mr. LEWIS. I am not that familiar with the health care provisions that you alluded to. But I believe that our tribe and other tribes would be attuned to any possibility of developing much more comprehensive services than we have for the elderly. The need is there. I am sure that the mechanisms could be developed if we were advised and informed as to what is available for us, what we can do with these resources.

Mr. MCNULTY. I think that gives a good opportunity to address at least some of the problems.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. McCain.

Mr. MCCAIN. Thank you, Mr. Chairman.

I would like to thank the witnesses for being here today. It is good to see Mr. Lewis here. I know from personal experience he runs an outstanding senior center which I have visited, and I recently had the honor to be present at your juvenile facility.

I would like to follow up what the chairman discussed, whether we should go further. It appears to me that title III, title VI, title XX, social services block grants, Medicare, Medicaid, community health, BIA services, and transportation—all are different programs with different bureaucracies, confusing certainly to this person who has just to observe them. It would be doubly confusing to someone who would have to be involved with receiving funds from these various programs.

Do you think it would be helpful or harmful if the Congress mandated an interagency work group along with tribal representatives to identify the obstacles to coordinated effort and make recommendations to Congress for changes? Would you comment on that?

Ms. TYNDALL. I think we do need to obtain more knowledge in the directions the tribes want to go. I don't think any delegate here is prepared to make a commitment. At least, I would not for my tribe. But I do feel it is necessary that we not only have legislation, but that we also have funding.

I think we also must bear in mind we are only talking about one segment of health. There is a very large population out there with very, very severe problems. The dollars are not coming to this particular need.

Mr. MCCAIN. Thank you.

Mr. Lewis, because of the somewhat unique situation of your reservation, practically surrounded by an urban area, a number of tribal members may not live on the reservation but nearby. You can comment better than anyone about your experience with the AHCCCS Program.

Can you comment on how that program has affected the ability of all the tribal members to receive health care?

Mr. LEWIS. It has not been as effective as it could be, mainly because of the disarray of the program, the circumstances in which it came about. The concept might have been helpful. But there was a misunderstanding about what it could do for the Indian people.

I think very little advance publicity came out. Indian Health Services did not give preliminary information. We had to seek out much of the information as to how we could benefit our people.

So I believe there was a delay as far as our tribe is concerned. I think it could have enhanced, and it has in some instances, the number of services available. Indian Health Services does reach a limit as far as its resources in any given year. The fact of the contract services that would have been available under AHCCCS, I think, were there. But, unfortunately, I don't think we were able to take as much advantage of it as maybe we could if the program in some form continues.

Mr. MCCAIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. McCain.

Mr. McNulty.

Mr. MCNULTY. Thank you, Mr. Chairman.

I would like to talk a little further about the business of combining title III and VI. I understand the Indian council acts for the statewide distribution of title III funds.

Mr. LEWIS. That is correct.

Mr. McNulty. Why would you be any better off not to have the division of these funds run through the intertribal council?

Mr. Lewis. I think what I am speaking about is an ideal situation. What title III has done is to accommodate; to make the best of a bad situation, I would say. Since we must receive these moneys as passthrough moneys from the State, we at least have the advantage of working with the intertribal council where we feel we are able to access their whole system of the State more effectively than we would as individual tribes dealing with the State.

So I guess, yes, there is an advantage. Beyond that, I guess what I am alluding to—why must we make these elaborate systems to deal with the moneys that are there? I think if tribes were recognized for what they are, there wouldn't be this need to try and accommodate ourselves and act like a political subdivision of the State in order to access these moneys.

What has been done is beneficial. But down the road I think we need a better means of distribution. That is what we want to suggest in title III and title VI.

There may be a better way to do it. But I think it is going to take, as was suggested, a combined task force to do this. And I think that should be done. I welcome that suggestion.

Mr. McNulty. Thank you, Mr. Chairman.

The Chairman. Thank you.

Mr. McKinley, I was impressed with the recommendations you made. You made some reference to the lack of transportation. Now, at every hearing that we hold throughout the country, transportation is always something that is discussed, and too many times we don't really know what the problems really are.

Would you, Mr. McKinley, just very briefly tell me what your problem is with regard to transportation?

Mr. McKinley. The transportation problem, I suppose, is a problem all over the Nation; much more so in the rural area. However, the transportation that is readily available is more for the general public and it doesn't reach the isolated high-risk elderly or any other deprived children or elderly. However, I think we have made tremendous progress.

In the Navajo Nation, we have a transit bus system that gives the elderly 50-percent discount. I do a lot of walking. Once in a while, I ride the bus. But also we have public service workers, such as the community health representative, the senior companion workers, the social workers, missionaries; and also for emergency problems we have the police system.

But we sometimes have recommended that the elderly be allocated so much—so many tickets a month for gas, because they are always hiring somebody to take them to a laundry or commodities or food stamps, to do their shopping and many other daily problems.

But I think we are making some progress in trying to help these people get to the market, and where they need to go.

The Chairman. Thank you very much.

I would like to compliment the panel for their testimony.

The panel is now dismissed. Thank you very much.

The Chairman. Ladies and gentlemen, we have a procedure in the House of Representatives whereby each Member of the House can take 60 seconds, 1 minute, to make any statement that they want. We are going to use that same system today. There is a microphone in the middle of the aisle.

If there is anyone who would like to make a statement for 1 minute—1 minute is 60 seconds. And this gavel will go down when the 60 seconds have been reached.

So if there is anyone who would like to make a statement for 60 seconds, now is the time. You may not get another opportunity today.

Who will be the first then to take advantage of the 60 seconds or the 1 minute rule?

Please give us your name and your address.

## STATEMENT OF JILL ERICKSON, VICE PRESIDENT, NATIVE AMERICAN SOCIAL WORKERS ASSOCIATION, ARIZONA CHAPTER

Ms. **Erickson**. My name is Jill Erickson. I live at 7733 East Camelback Road, apartment 135 in Scotsdale. I am vice president of the Arizona chapter of the Native American Social Workers Association.

We have written testimony to present to the committee and put in the record.

The **Chairman**. Your written testimony will be included in the files of today's hearing record.

You may proceed for an additional 40 seconds.

Ms. **Erickson**. Our testimony is being presented in the form of a prototype case study, illustrating many of the issues we have identified. We feel that the problems are typical of any reservation in the country.

Mary is a 63-year-old Indian woman with rheumatoid arthritis in her hands and knees, diabetes, hypertension, and obesity. She cares for three granddaughters and her disabled father.

The 4- and 5-year-old girls live with Mary because their father is in jail. The third is 15 years old, pregnant, and known to sniff paint. Great grandpa is diabetic, blind, and has a below-the-knee amputation of one leg. He is confused and fights the visiting nurse when she comes to take care of him.

Mary comes to see the local social workers because there is no money for rent, food, or the electric bill of $400. The utility company is threatening to shut off the power and the 100-degree weather is approaching.

Great grandpa's Social Security check has been the only source of income and it has been withheld due to $800 income in Indian land money, received 1 year ago. The family lives in his senior citizen complex apartment.

Mary's father is facing a second amputation and the nurses are insisting that he will need to go to a nursing home. Due to a unique policy decision in this State, he will be ineligible for Social Security in a nursing home. This policy is inconsistently applied. Grandpa would have to be placed in a nursing home a 4-hour drive away.

The family members are eligible for benefits in their own rights but must be referred to at least eight different organizations some

30 miles away and face delays due to requirements for documents they do not currently have. They have no transportation.

ANSWA, as advocates for our clients, want to stress the amount of services Mary requires to keep her family together and have their basic needs met. We recommend the expansion and coordination of existing resources to better serve our Indian communities.

VOICE. My name—I am with the—tribe. We live up near the State of Utah, right on the borderline. Today we talked about coordination of community services.

I feel that one aspect of coordinating these services would be to also provide training for the community for giving adequate services to the elderly. And these would be provided training for volunteer groups.

Because we are talking about a lack of funding, lack of coordination between community support services. And therefore I feel that training for people within a community is very important also.

This is not only for Indian communities, but for every community in the State of Arizona.

The CHAIRMAN. Thank you.

## STATEMENT OF KENNETH CODY, CHAIRMAN, NAVAJO NATION COUNCIL ON AGING

Mr. CODY. Honorable Congressman and members of the hearing committee, my name is Kenneth Cody and I am a national Indian aging advocate. I have been active in advocating on behalf of the elderly of the Navajo Nation for years. In 1981, I was privileged to be a part of the Navajo delegation to the White House Conference on Aging. Since that time I have attended many conferences; most recently the National Conference on Aging in Washington, DC.

During that time I spoke with Commissioner Toliver and on many previous occasions I have given testimony as to the needs of the Navajo elderly. In fact, I am here today because I am beginning to wonder where they have been sent.

For this reason, I wish to submit to you as part of my testimony these documents which represent the needs and recommendations of the Navajo elderly for the past 8 years.

I would like to add that the lack of an Indian aging policy has delayed adequate funding appropriations and recognition of Indian tribes. In addition, due to no aging policy, Indian requests for services and programs are limited by the Federal Government.

For this reason, we must enforce our right to have an Indian aging policy. Therefore, I, again, present these previous recommendations submitted in good faith to illustrate the cooperation we, the Navajo Tribe, have extended and the lack of response we have received.

The CHAIRMAN. Thank you.

[Additional material was subsequently submitted for the hearing record from the Navajo Nation Council on Aging. That material may be found in the appendix.]

VOICE. I am from New Mexico. I am glad to see our Congressmen. I will read my report.

I am requesting the following for the elderly. We need a senior building, a workshop, and about 100 chairs. The chairs we have now belong to the tribe.

We have to move them back and forth. Not long ago we had visitors from overseas. These speakers were on the platform and we were sitting in the bleachers.

And they wanted us to move the chairs close to them. But our chairs were in the dining room. And then it was near noontime. Instead of we moving to the front, they had to move the platform toward where we were, and that didn't look very nice.

That is all we are asking for, for chairs to use for our own. And also trays to eat with. When we have visitors, a lot of them come—because we all eat at once. About 48 people in the dining room.

Some will have to eat in the dining area or sit on the side. So that is what I am asking for—a new building. I hope to see that we get it some day.

Also, we need a driver. We don't have a driver. The cook has to drive the van to go after those that cannot walk. And after she brings them to the mealsite, she has to go out and deliver the trays for those homebound.

The CHAIRMAN. Your time has expired.

## STATEMENT OF MARTIN BIRD, CHAIRMAN, NEW MEXICO TITLE VI INDIAN COALITION

Mr. BIRD. Honorable Chairman, honorable members of the Select Committee on Aging, I am Martin Bird, from Santa Domingo, NM. I am representing the New Mexico Indian Council on Aging and also the Indian New Mexico Title VI Coalition. I would like to just briefly summarize our recommendations.

One, development of a national Indian aging policy, initiated and prepared by the U.S. Native Indian Americans.

Two, previous title VI recommendations reviewed, approved, and implemented by fiscal year 1986—October 1, 1985.

Three, clarification of roles by Administration on Aging—Health and Human Services, HHS-AOA—U.S. Bureau of Indian Affairs [BIA], Indian Health Services-Public Health Services [IHS-PHS], U.S. Veterans' Administration [VA], Social Security system—including supplemental security income [SSI], et cetera.

Four, request that you as representatives of your respective areas, along with President Reagan's administration, and all future administrations, for a change, honor and fulfill the responsibilities of the Government and the long list of broken treaties.

Five, inhouse health care is our priority before we consider a nursing home of any kind on or off the reservation. We firmly support all preventative services.

The CHAIRMAN. Thank you.

[EDITOR'S NOTE.—Additional materials submitted for the hearing record by Martin Bird may be found in the appendix.]

## STATEMENT OF TRUDY NARUM ON BEHALF OF THE PUEBLO OF JEMEZ, NM

Ms. NARUM. I am Trudy Narum. I am a registered nurse.

Mr. Chairman, I will just submit a prepared statement for inclusion in the hearing record and not take the committee's time to read it, if that meets with your approval.

The CHAIRMAN. Yes; that will be fine. Your statement will be printed in its entirety in the appendix of today's hearing.

[EDITOR'S NOTE.—The statement submitted by Trudie Narum on behalf of the Pueblo of Jemez, NM, may be found in the appendix.]

The CHAIRMAN. The people who testified this morning were not selected by this committee. They were selected by the community itself. That was the purpose of this hearing.

We are making available now to the community additional time to be heard. This is far beyond the intent and rules and regulations of any committee of Congress.

It is something we make available because we have had the time. We could give each one of you an hour, but we don't have that much time.

I have come a long way to be here in Arizona. I could be in my own district. But I am interested in the problems of the Indian community of Arizona, New Mexico, and the Southwest. And the time we are making available now is to hear from the public for 1 minute.

If we had more time this afternoon, we would make more time available.

Mr. MCCAIN. Mr. Chairman, I would also like to express the appreciation of the people in Arizona for your presence here, not only as chairman of the Committee on Aging, but also as a member of the Appropriations Committee.

I am very appreciative of you holding this hearing and allowing all of the Indians or anyone else who is interested in this issue to speak.

I thank you.

The CHAIRMAN. I thank the gentleman.

Mr. MCNULTY. Mr. Chairman, when I came to the U.S. Congress 17 months ago, I could not believe it when I heard people walk down on the floor of the House of Representatives and say, "Mr. Speaker, I ask unanimous consent of the House of Representatives to address the House for 1 minute." And I thought, well, that is just a figure of speech. These guys, they can talk at great length. They are not serious about that.

Then I noticed the man standing next to the Speaker with a stopwatch. And I noticed that when the 1 minute was up, the man with the stopwatch nodded at Speaker O'Neill or whoever was sitting in that chair, and the gavel came down. And I thought, my goodness, that is pretty harsh way to treat Members of the Congress.

What it all boils down to quite simply are two things. One, time is a very precious commodity. It simply has to be rationed.

Now, there are two ways of approaching the subject.

The point quite simply is with a precious commodity that has to be rationed, there are one of two things you can do. Somebody can decide who are the people we really ought to hear, which means that the large numbers of folks are not going to be heard at all, or we can go to this kind of egalitarian system of giving just little bits of time to lots of folks.

Frankly, I prefer that method.

Let me say one other thing about this 1 minute business. Any time you go through that discipline, it tends to focus your mind on what you really care about, so that 1 minute comes from the heart, from the gut, and none of the flowery stuff that we normally associate with speeches.

You take that little 1 minute of time, you decide what is most important, most vital to you, the thing that you most would want to convince people to share your belief. And I think out of that, even thought it is rigorous, it is harsh, out of that I think comes a real focusing of the things that are most deeply troubling to us.

I want to kind of rally around the chairman here. That system isn't great, but it doesn't stink either.

The CHAIRMAN. Will you please proceed?

## STATEMENT OF CAROLYN TOOTSIE, REPRESENTING THE HOPI TRIBE

Ms. TOOTSIE. I am Carolyn Tootsie of the Hopi Tribe, speaking for the Hopi Tribe, speaking for the Hopi elderly. I just want to say thank you.

My first recommendation is to start with a day care center, and I think this is the first step toward taking care of the elderly as it has been requested of me several times that I give this time, 8 to 5 to provide services to the community people so they can work, and they will take the responsibility to work and take care of the elderly during the evening hours, and weekends.

But this is not—we cannot possibly do that with our CHR programs today.

The second one is I am requesting that you take a closer look to the regulations and work this out between title III, title VI after all the other titles so that we can be able to provide better services to our people.

The third one that I want to say, and this is the last one, making nursing homes a reality on the reservations so we as a tribe can uphold our culture. And one statement that I will have to say, we as a tribe make every effort once a year to provide a cultural activity for our people that are in off-home nursing reservations.

Thank you.

The CHAIRMAN. Thank you.

## STATEMENT OF VIRGINIA TAYLOR, ON BEHALF OF THE HOPI TRIBE

Ms. TAYLOR. I am Virginia Taylor. I am from the Hopi Reservation working with Mrs. Tootsie. I would like to see some changes in the regulations in Social Security where it reflects the care in long-term care custodial. This money has been taken away and it is now hurting our elderly.

This is what I would like to see. I would like to request a facility be built on the reservation. I will not be able to make this long trip to visit our elderly in a long-term care in the Phoenix area.

Also I would like to see beds be available in Indian health care facilities for long-term care.

The CHAIRMAN. Thank you.

## FURTHER STATEMENT OF DR. NED ANDERSON, TRIBAL CHAIRMAN, SAN CARLOS APACHE TRIBE

Dr. **Anderson**. Mr. Chairman, and members of the panel, I was on a panel earlier, and we were entrusted with the responsibility of perhaps coming up with some recommendations.

I would now like to put in the record eight recommendations that were made by the panel.

One, legislatively mandated Indian desk at two levels: First, Administration on Aging; and second, Office of Management and Budget above all for the purposes of coordinating the flow of Federal funds directly to Indian tribes.

Two, direct funding to Indian tribes including title III and title V.

Three, reservation-based skilled nursing home care.

Four, government-to-government recognition to negotiate and develop aging services and programs.

Five, development of a consolidated set of regulations and procedures, funding and administrative, for aging programs and services, including cultural and traditional considerations.

Six, more flexibility in Public Law 93-638 client eligibility criteria, including group eligibility.

In connection with Public Law 93-638, it has been the experience of all Indian tribes that whenever there is a question or conflict in contract terms, that there has been no indifferent, disinterested party to mediate. And we feel there ought to be provision made for that.

Seven, legislative mandate to have BIA and IHS to provide equal and concurrent services to the elderly.

Eight, revise regulations to allow title III and title VI to be coordinated.

There may be additions made to these recommendations, Mr. Chairman. Thank you.

The **Chairman**. Dr. Anderson, I would like to thank you for very excellent recommendations. Be assured that the recommendations have been read into the record, and will be made to the various legislative committees.

I will personally write a letter to the chairmen of those committees asking them to consider the recommendations that have been made.

Dr. **Anderson**. Thank you.

The **Chairman**. I will also send you a copy of the letter that I send to the chairmen. Then you can act in a manner that you may desire in submitting perhaps your own letters to the chairmen of the committees in question.

I thank you very much, sir.

Dr. **Anderson**. P.O. Box 0, San Carlos, AZ, 85550. Thank you.

The **Chairman**. Thank you. We will hear from the next two witnesses and then recess until 1:30.

## STATEMENT ON BEHALF OF THE PAPAGO TRIBE (UNIDENTIFIED SPEAKER)

**Voice**. Good morning, Honorable Congressman.

The Papago Reservation is located 65 miles west of—it covers 8 million acres divided into 11 districts. Of the 18,000 population, approximately 2,000 are elderly.

Only 754 of those are over 60 years of age. Under title VI and title III which are separated due to regulations making it very difficult for us to keep so many sets of books to comply with Federal and State regulations.

Remote distances between several centers are 60 to 90 miles, which our workers travel daily. Among many other needs, transportation and health care facilities, our greatest need is there is no long-term facility as such on our reservation.

Even though there is a need, our tribe realizes that there is a need, we do have 44 elderly outside of the reservation in nursing homes.

Construction funds, financial banking are problems experienced by other tribes as we heard yesterday. Still look for other options.

Comprehensive training and home health care services is a pilot program only, where we service only 3 districts of 11 districts. If we do get the funds. Our tribe has never met the minimum level of services for our elderly. Serious consideration should be—in these areas.

In closing, we would like the right to submit further comments and recommendations, and to the committee I would like to say that you have an open invitation to our reservation, to come and see for yourself our situation.

The CHAIRMAN. Thank you.

The last witness is Governor Norris.

[Prepared statement of Dana R. Norris may be found in the appendix.]

## STATEMENT OF DANA R. NORRIS, GOVERNOR, GILA RIVER INDIAN COMMUNITY, ARIZONA

Mr. NORRIS. Thank you very much, Mr. Chairman, members of the House and Senate. I appreciate this opportunity to address the distinguished group today.

My name is Dana Norris. I am the elected governor of the Gila River Indian Community and our reservation is located generally south and east of Phoenix, AZ. I am here today to state my concern with respect to long-term care of our elderly Pima and Maricopa Indians.

We accord our Pima and Maricopa elders much respect since not only are they the carriers and transmitters of our cultural heritage and traditions, but also because each has contributed to the continued survival of Pimas and Maricopas. Pimas and Maricopas, like all tribes, have always attempted to provide the best possible resources for our elderly, especially health and social services.

We have one residential facility for long-term care on the Gila River Indian Reservation and more such facilities are needed. Once the new hospital in Sacaton is completed, now scheduled for 1987, it may be advantageous to construct a long-term care facility in Sacaton near the hospital. In any event, the community and this Nation owes a debt to the elderly which must be paid and increased appropriation is only one avenue which may be traveled.

I now shall direct my remarks to a specific situation of immediate concern.

The elderly who need to live in an institution have had their funding reduced over the last 2 years by an informal rule of the Social Security Administration which seriously injures elderly Indian people.

If an elderly person is staying in a private nursing home under contract to a local or State funded program, they can get SSI benefit. This money is generally used to help pay for their care and for a small living allowance for personal expenses.

However, the Indian elderly are not treated as favorably. Because elderly Indians living on or near their reservation cannot get State assistance, they normally have their nursing home care provided through funds administered by the Bureau of Indian Affairs.

Starting in late 1981, the Social Security Administration changed their rules and said that persons living in institutions receiving institutional care funding from the BIA would no longer be eligible for SSI. Not only did they stop pay benefits to the elderly, but they tried to collect overpayments from many nursing home residents for previous payments made by the Social Security Administration.

This rule change has caused serious harm for elderly Indian people. It has reduced greatly the total dollars available for institutional care.

It has denied individuals the personal living allowance they would be entitled to if they were being funded by a State or county program. Finally, this new rule denies the elderly Indian that dignity and self-worth which comes from contributing to one's own cost of care.

Several handicapped persons who have had their SSI benefits denied, reduced, or terminated because of this new rule are currently challenging the rule in court. However, with appeals, this court action could take several years.

Congress could easily solve the problem by requiring that BIA institutional care funds be treated the same as other in-kind income received by SSI recipients.

In many instances individuals challenging this new rule are being represented by attorneys funded by the Legal Services Corporation. Under new restrictive rules by the Legal Services Corporation, these attorneys are prohibited from contacting Congress, or assisting or suggesting that others contact Congress until after all judicial remedies have been exhausted.

Attorneys representing eligible elderly clients should once again be allowed to bring their clients' problems to the attention of Members of Congress and I request that this committee express this concern to the appropriate committee which oversees the Legal Services Corporation.

Finally, I suggest that this committee explore alternatives to institutionalization of the elderly. One alternative is foster family placement for certain elderly Indians supported with Federal funds. Placement with a member of an extended family or other Indian family on the Gila River Indian Reservation should be explored.

I thank you for your attention to our concerns.

The CHAIRMAN. Thank you.

Ladies and gentlemen, you probably noticed that the governor went far beyond his 1 minute. That was done purposely. To demonstrate the fact that there was a written statement, that that written statement would have appeared in the record even if it had not been read.

It is an excellent statement. I am pleased to make it a part of the record at this point.

What I am saying is anyone who takes 1 minute, can also write a statement. The rule is that the record will remain open for 2 weeks and within 2 weeks anyone in this audience that wishes their statement to appear in the record can write that statement and send it to the committee and the committee will include it in the record as if it had been read under this 1-minute rule.

The Chair now recognizes the last witness.

VOICE. I am director of the area agency on aging in Tucson, AZ. I just come before you to say thank you for doing our city honor in holding this meeting today. I want to thank all those tribes who have come so far and to appear here. And I want to tell you that this area agency will do its best to assist you in maintaining your tribal independence, your customs, and assisting you with technical assistance in any way that we may be able to, to meet the very difficult Federal rules and regulations under which we all live.

However, should the funding be adequate to meet the services and needs of the older people and to provide us services in the way that the Congressman all wish will be provided to their parents when they are old, I am sure we will have to focus less on the coordination and administrative difficulties which appear at this time so insurmountable. Thank you for my minute.

The CHAIRMAN. The committee will be in recess until 1:30.

[Whereupon, at 12 o'clock noon, the committee recessed, to reconvene at 1:30 p.m., the same day.]

### AFTER RECESS

The CHAIRMAN. The committee will resume its sitting.

Ladies and gentlemen, I am pleased to acknowledge the presence of Congressman Mo Udall. We announced this morning he was in flight, that he would be here this afternoon. It is now my privilege to acknowledge his presence and turn the meeting over to him for any remarks he may wish to make at this time.

Mr. UDALL. I thank you, Chairman Roybal. It is a great honor to have you come to Tucson; and it is a privilege to work with your Select Committee on Aging on the important problems of care for elderly Indians. It is a subject that has been neglected too long.

I wish I could have been here this morning, but my schedule was such I could not fly to Tucson last night and be here all day today. But I am intensely interested.

I just want to say that Chairman Roybal is one of the really influential people in the Congress and the country. And for him to take his time to give his attention to this problem is a real pleasure and honor for all of us.

I also wanted to say not too long ago somebody gave me an award for being a great legislator. They said I learned the trick of getting good people, delegating the work to them, and backing them up. The subject of Indian affairs on our committee is one which nobody has much time to devote to. In fact, it was considered a sure way to unpopularity to become an authority on Indian matters. But Jim McNulty and John McCain were both on my committee and I asked them to take over and spearhead Indian affairs legislation the last couple of years. They have done a hell of a job and produced good, solid legislation and more worthwhile hearings than has happened in our committee in a long time.

So I came today to attend part of the hearing, to listen to the witnesses, and to see what advice we can get; and then, working with Chairman Roybal and Mr. McCain, Mr. McNulty, and others, I hope this year, and if not this year, then in the new 99th Congress, we can take some action along the lines of the testimony and recommendations that will be heard in these hearings.

I am delighted to be part of the hearings. I look forward to participating today. Thank you very much.

The CHAIRMAN. Thank you, Congressman Udall.

The Chair wishes to apologize for being late due to a press conference that was held. I was asked the question by members of the press, "What did you learn this morning?" And I summarized the various recommendations that were made.

I told them there were eight recommendations made by members of the panel representing different tribes in the State of Arizona. These recommendations, I told them, will be taken back to Washington, DC, will be made available to members of the Committee on Aging as well as the Committee on Interior, and then a joint letter will be written to the proper committee, that is, the committee that finally tracks the legislation, recommending that the eight recommendations be given consideration. I think that once that is done, they not only will be given the necessary consideration but that they will become part of the legislation that is being drafted now.

You probably all know—I am sure that you do—that the legislation has already been drafted by the Senate, that the House is working on it. That is the reauthorization bill. That act must be reauthorized sometime this year. It is our hope that the recommendations that were made this morning will become part of that piece of legislation.

I think that in general, I told the members of the press, is the reason why we are here, and we are going to do everything possible to comply.

Now, the Chair will recognize the next panel. The panel this afternoon will be made up of Bart Graves, Dr. Vanderwagon, Mr. John O'Hara, and Mr. Jack McCarthy. Will the members of the panel please take your respective seats before the microphones. And I will ask Mr. Bart Graves to start off the discussion.

[Prepared statements of J. Bart Graves, Craig Vanderwagon, John O'Hara, and John McCarthy may be found in the appendix.]

## PANEL CONSISTING OF J. BART GRAVES, PHOENIX AREA SOCIAL WORKER, BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR; CRAIG VANDERWAGON, OFFICE OF PROGRAM OPERATIONS, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOHN O'HARA, ASSOCIATE REGIONAL ADMINISTRATOR FOR PROGRAM OPERATIONS, REGION IX, HEALTH CARE FINANCING ADMINISTRATION; AND JOHN McCARTHY, REGIONAL PROGRAM DIRECTOR, REGION IX, ADMINISTRATION ON AGING

Mr. GRAVES. Mr. Chairman, Mr. McNulty, Mr. Udall, Mr. McCain, my name is Bart Graves. I am the area social worker for the Bureau of Indian Affairs, Phoenix area office. I am representing James Stevens, Phoenix area director.

I would like to provide a statement on the Phoenix Area Social Services Program and its relationship to the 46 tribal governments served by the Phoenix area.

The Indian Affairs Social Services Program is a typical public welfare program of general assistance, child welfare, emergency assistance, and caseworker services. In this fiscal year 1984, we will expend about $18 million for social services to members of the Phoenix area tribes, a monthly average of 6,000 cases involving 11,000 persons.

Under the authority of Public Law 83-638 the social services program has been a high priority for contracting for Phoenix tribes. In this year, all but 7 of the 46 tribes are receiving bureau social services through 638 contracts.

Another indication of the priority for social services is in the fiscal year 1984 national tribal budget priority setting process, social services was 11th of 34 programs. In the Phoenix area, social services was ranked number 4.

Based on this high degree of tribal involvement with human services programs, it is our assessment that Phoenix area tribes would and can demonstrate a strong commitment to develop strategies and programs for the care of elderly Indians.

One important component of our social services program is adult institutional care. This is part of our general assistance program and it provides supportive care to adult Indians in need of custodial or supervisory care due to emotional and physical conditions.

This care is provided through a range of services including supportive services for the individual in his home, adult foster care, group living, and nursing care below the skilled care level.

Our objective in the Phoenix area, and I believe it is that of the tribes we serve, is to have that care available and provided within the Indian's home community. We have made some progress in meeting this.

Ten years ago all of this care was provided in off-reservation facilities. Today it is about one-third that level. The rest of the services are now provided within the tribal communities.

We have had one problem which Governor Norris mentioned this morning. The bureau contribution supplement for residential care of adult Indians, when that person is receiving SSI benefits, our contribution is considered income by the Social Security Administration. So eventually by supplementing that care, which an Indian cannot purchase based on his SSI payment, eventually he loses his SSI entitlement and the bureau is fully funding that residential care.

This has several meanings. The SSI recipient is automatically categorically entitled to the State AHCCCS Health Benefit Program. He loses that entitlement. He has to apply as an individual and generally these people are unable to do so, in terms of their infirmity and other factors.

When the person leaves residential care, then he has to apply for SSI again. And this is not an easy, uncomplicated process.

It is our feeling that this has meant between 300 and 400 Arizona Indians that we serve have lost their SSI benefits over the past year and a half.

We do not believe that this supplement payment or residential care was intended to be countable income. We ask for consideration of this factor.

We do believe that there should be a continuum of services available for elderly Indians to help meet their needs as they become older and less independent. For those who can no longer live at home, a variety of resources should be available which provides alternatives to institutional care, and we would support that that be available in as most open a setting as possible.

Thank you.

The **Chairman**. Thank you, Mr. Graves. Dr. Vanderwagon.

Mr. **Vanderwagon**. Mr. Chairman, members of the committee, I am Dr. Craig Vanderwagon. I am with the Office of Program Operations in the Indian Health Service, Rockville.

I am pleased to be here today to discuss the programs from Indian Health Service, particularly with regard to the Indian elderly. As you are aware, the Indian Health Service provides a comprehensive program encompassing preventive, acute, and chronic care services to American Indians and Alaska Natives of all ages. The hallmark of the IHS program has been a balanced set of services designed to meet the epidemiologically defined needs of our Service population.

The success of this balanced, epidemiologically defined set of services is attested to by the increasing life expectancy at birth of American Indians and Alaska Natives. A recent report prepared by the IHS staff analyzed the life expectancy at birth of our Service population for the period 1969–71 and compared these statistics to similar data from the period 1979–81.

This study revealed that in the 10-year period described, the average life expectancy at birth for American Indians and Alaska Natives of both sexes increased an average of 6.0 years. The members of our Service population may expect to live to an age of greater than 70 years. While this is still below the figures for the U.S. population of all races, who may expect to live to 73.7 years, it does reveal that an aging population is developing in Indian country.

Currently the population over age 65 constitutes 5.2 percent of the IHS service population. In absolute numbers, this means that 47,700 individuals of the 930,000 IHS service population are over age 65. Of this elderly group, approximately 22,000 are eligible for Mediare part A, and 12,000 are eligible for both parts A and B.

Under provisions of Public Law 94-437, the IHS is allowed to bill Medicare for services provided to eligible Indian patients. The funds recovered under these provisions are by law to be used to redress Joint Commission on Accreditation of Hospitals deficiencies. In fiscal year 1983 the IHS collected $14,681,000 under Medicare, and 10,690,000 under Medicaid.

The provision of health services to this population requires many resources. In fiscal year 1983, the number of visits to IHS ambulatory facilities by patients older than age 65 accounted for 10 percent of all visits. The number of inpatient hospital days accounted for by this group totaled greater than 15 percent of hospital days for patient care in IHS hospitals.

An analysis of resource intensiveness reveals that services provided to those over 65 years were more resource intensive than for younger patients. If national trends in this population may be extrapolated to our service population, the use of IHS acute services by the elderly will increase resulting in an ever greater proportional use of IHS resources.

The Indian Health Service recognizes these trends and has developed a number of programmatic approaches to address the issues of health care for the elderly.

In the area of preventive programs, IHS has, either through its directly operated facilities or in conjunction with tribal health programs, initiated many activities. In its directly operated programs specific curricula have been developed in nutrition, health education, environmental issues, and disease-related areas to increase health maintenance behaviors in elderly populations. This is typified by the Central Diabetes Program in the IHS.

This program, which utilies a multidisciplinary team, has been operational for 3 years. The program emphasis has targeted the prevention of such catastrophic sequelae of type II diabetes as amputations and end-stage renal disease. Through the collaborative efforts of IHS providers, tribal community groups, and the National Diabetes Advisory Board, a program was developed to prevent the above problems which incapacitate many, primarily older, Indian patients.

IHS-funded tribal health activities also reveal many efforts in this area. Tribally operated community health representative programs have had as a main emphasis, health promotion among elderly populations. This is a well-defined element of the scopes of work negotiated with the tribes for community health representatives.

Acute care for the elderly is a vital, ongoing element of the IHS Program. As the statistics presented earlier suggest, the elderly receive care in expected frequencies. The acute care program encompasses a full range of ambulatory and inpatient care.

Chronic care programs utilize ambulatory, inpatient, and community services. These programs involve a variety of providers including physicians, nursing personnel, both in facilities and communities, nutritionists, dentists, physical therapists, and many others. These programs reflect the efforts of IHS and tribal employees.

Our efforts in providing chronic care to the elderly and others is typified by programs involving the collaborative efforts of IHS provides and tribally operated home health care agencies. In these activities, IHS providers work together with tribal employees to effectively develop discharge and home care plans for elderly individuals discharged from inpatient care but requiring continued care in the home.

The continued monitoring of the patient's health status by this team is paramount to early diagnosis and intervention or prevention. This approach has proved successful in many locations over time. The Zuni Tribal Home Health Care Agency has, for example, been quite successful over the last 3 years in working closely with the staff of the IHS Zuni Comprehensive Health Center.

These examples serve to demonstrate how the IHS has developed programs appropriate to the needs of an aging Indian population. Further refinement of the approaches to these issues is ongoing. The IHS is part of the Indian Elders Initiative Task Group sponsored by the Office of the Assistant Secretary for Human Development Services. this task group, which has representation from the Administration on Aging, the Administration for Native Americans, the Indian Health Service, and other elements of the Department of Health and Human Services, is working steadily to enhance and coordinate policy development in Indian elderly health care issues.

I hope that this illustrative, rather than exhaustive, presentation of information aids the committee in its understanding of the Indian Health Service approach to health care for elderly American Indians and Alaska Natives.

Thank you.

The CHAIRMAN. Thank you, Dr. Vanderwagon.

We now recogize Mr. John O'Hara.

Mr. O'HARA. Thank you, Mr. Chairman, members of the committee. I am John O'Hara, Associate Regional Administrator for Program Operations for region IX of the Health Care Financing Administration. I am pleased to be here today to represent my agency in your deliberations concerning long-term care and Native Americans. In my statement I will describe the Medicare and Medicaid Programs and the roles they play in financing long-term health care for the Indian people.

Medicare is designed to provide primarily acute care services, which consume about 95 percent of program expenditures annually. However, a limited amount of care is provided under Medicare in what are traditionally considered long-term care settings, such as skilled nursing facilities [SNF's], home health agencies and hospices. Beneficiaries who require skilled care can receive it on a daily basis as an inpatient in a SNF on a time-limited basis or at home on a part-time or intermittent basis from home health agencies. Terminally ill Medicare patients also can now elect to receive hospice care in lieu of regular Medicare coverage.

Today, over 26 million aged and another 3 million disabled persons are covered under Medicare. Prior to Medicare many of these people did not have access to adequate health care. For much of this population Medicare has assured that they need not fear the burden of high hospital or physician bills.

To become eligible for Medicare, an individual must be at least age 65 or be determined by Social Security to be disabled, and must have worked for a certain period of time at a job that was covered under the Social Security retirement system.

In discussing the eligibility of the Indian population for Medicare, it is useful to distinguish between those who live on the reservation and are part of the service population of the Indian Health Service, and those who have moved into the broader community. Of the IHS service population of 909,000, about 47,000 are age 65 or over. Of this group, it is estimated that less than half are eligible for Medicare because of limited earnings records and other factors.

It is expected that this percentage will improve in future years. That part of the Indian population which is not part of the IHS service area amounts to about 630,000, including about 33,100 age 65 or over. Although data are limited, this group is estimated to have Medicare eligibility levels closer to the general population.

The Medicaid Program, which is administered by the States within broad Federal guidelines, traditionally has had an emphasis on meeting the long-term care needs of the poor. Over half of the annual program expenditures are for long-term care services. Medicaid covers care provided by a SNF or an intermediate care facility [ICF], as well as care provided through home health agencies and by other individual practitioners—such as a nurse—who go to a patient's home. However, in Arizona, the long-term care needs of the indigent population continue to be met through county resources.

In addition, Medicaid, unlike Medicare, allows States to cover the provision of certain personal care services under the Home and Community-Based Waiver Program. States may seek waivers of certain Medicaid regulations to establish programs of home and community-based care targeted at groups of individuals who are at risk of institutionalization.

The Medicaid Program is designed to provide health care for certain groups of low-income people, primarily those already receiving cash assistance. This generally includes members of families with dependent children and the aged, blind and disabled. In addition, States may choose to pay for the care of those individuals who are medically needy—that is, families who have enough income to pay for their basic living expenses, but not enough to pay for their medical care.

Currently, 20 States and territories cover only those individuals receiving cash assistance, and 34 States and territories cover both cash assistance and medically needy receipients. It is these general eligibility conditions that Indians, as others, must meet in order to qualify for Medicaid. With the exception of care for the Indians, the cost for Medicaid services are shared by the Federal and State governments. The Federal Government fully funds States for all Medicaid services provided to Indians in IHS facilities.

Recognizing that Indians who live on reservations do not always have access to participating Medicare and Medicaid facilities, Congress enacted provisions in the Indian Health Care Improvement Act of 1976 (Public Law 94-437) to pay IHS for Medicare and Medicaid services provided in IHS facilities to Indians eligible for these programs. The law requires that these payments be used to upgrade and maintain the quality of IHS medical facilities so that they meet Medicare and Medicaid standards, which has happened.

To date, over $80 million has been paid to the IHS for Medicare and Medicaid services provided to Indians.

Under Medicare, the IHS may receive payment for services provided to beneficiaries in hospitals or skilled nursing facilities operated by the IHS or a recognized tribal organization. Under Medicaid, the IHS may receive payment for services provided to Medicaid recipients in hospitals, SNF's and ICF's. The IHS facilities must meet all Medicare and Medicaid health and safety standards in order to receive payment by either program.

However, because the IHS health care system is geared to meeting preventive, acute care and ambulatory care needs, it does not operate any SNF's or ICF's as such. Its focus has been on working closely with the Bureau of Indian Affairs in devleoping community-based programs which can provide coordinated health and social services for the elderly. The IHS does assist the patients in gaining access to appropriate long-term care facilities outside the IHS system.

As you can see, both Medicare and Medicaid payments are available for services provided to Indians by IHS facilities or by facilities operated by recognized tribal organizations. For those Indian people living off the reservation who are not part of the IHS service population, Medicare and Medicaid payments are available to their local health care providers to the same extent as to other eligible citizens.

There are a few demographic and other factors which limit to some extent the amount of these services that are provided. Currently, only about 5.2 percent of the Indian population is age 65 or over, contrasted with over 11 percent of the total U.S. population. Recent increases in life expectancy are expected to raise this percentage substantially over the next few decades.

Another possible limiting factor is the widespread dispersion of this group of elderly people. Concentrations of elderly are not available in a way that would lend themselves to economical institutional settings such as nursing homes. This, in part, contributes to the need to focus on community-based care and home care.

In conclusion, we understand only too well the challenges that must be met to assure that all our citizens have adequate access of necessary care and services. Meeting the long-term care needs of the Indian population present particular problems, and we have been worklling to see that we do our part in meeting these needs.

My agency stands ready to coordinate Medicare and Medicaid resources with other public and private resources to assure that the needs of Indians are met in the best way possible.

Thank you.

The CHAIRMAN. Thank you.

The Chair now recognizes John McCarthy.

Mr. MCCARTHY. Mr. Chairman and members of the Select Committee on Aging, and the Committee on Interior and Insular Affairs, I am John McCarthy, the Regional Director of Region VIII, Administration on Aging.

I am pleased to appear before you today to explore the impact of long-term care issues on health and social services for older Indians. The Administration on Aging has a longstanding interest and commitment to long-term care systems for the vulnerable elderly, in particular those long-term care systems that are community based.

The Older Americans Act was enacted in 1965. Title II of the Older Americans Act establishes the Administrating on Aging [AOA] as the principal Federal agency for carrying out the provisions of the act. These provisions also require AOA to coordinate and assist in the planning and development of programs for older individuals by public and private organizations with a view to establishment of a nationwide network of comprehensive, coordinated services and oportunities for such individuals.

This title also describes the basic roles and functions of AOA important among these are to administer the programs authortized by Congress under titles III, IV, and VI of the act, and to serve as an effective and visible advocate for older persons within the department and with other agencies and organizations.

This mandate to develop community-based services has implications with respect to long-term care. We, at the Administration on Aging, view a long-term care system as much broader than institutions such as hospitals or nursing homes. As you know, during the middle portion of this century, American social policy somewhat inadvertently created a reliance on institutions as a major mechanism for providing long-term care.

The phrase "long-term care" became associated primarily with health care provided in hospitals and other medical facilities such as nursing homes, extended care facilities, and rehabilitation centers.

Beginning in the late 1960's, however, efforts to create alternative approaches to that reliance on institutions gathered force. The programs of the Administration on Aging have been an element in this reform. In recent years, it has become increasingly clear that long-term care should not be exclusively medical or institutional. Rather, it is now generally recognized that long-term care has supportive services dimensions, and that for most persons it can be provided in a variety of noninstitutional settings including an individual's own home as well as supervised community residences, family-style boarding homes, and foster care homes for adults.

The Administration on Aging is currently involved in two major efforts to expand the base of knowledge about long-term care and to facilitate development of community-based programs, namely, the Channeling Demonstrating Program—in partnership with the Health Care Financing Administration—and the Long Term Care Gerontology Centers Program. I shall discuss this more in detail later but first I want to share with you the kind of activities the Administration on Aging is supporting through titles III and VI of the Older Americans Act.

I would like to begin with a brief history of the title VI program and a description of its current status. As most of you know, title VI was enacted into law as a result of the 1978 Amendments to the Older Americans Act. Earlier legislation had given priority to elderly minorities and low-income seniors. However, there was a general consensus on the part of Indian organizations, tribes, and national aging organizations that older Indians were not receiving equitable services under the act.

Although many Indian elders benefited from OAA services, in general they remained largely an underserved population. In addition, where the Indian older persons were being provided services under title III, often this was accomplished in ignorance of essential cultural values which further alienated the Indian older persons from participating in the program. As a result, concerned Indian tribes, organizations, and individuals began to advocate for a mechanism of direct funding to Indian tribes. This effort was formalized at the 1971 White House Conference on Aging by presenting specific recommendations to address the needs of Indian elders.

In 1978, Congress amended the act to include title VI which provided for direct award of grants to Indian Tribes. Title VI provides for nutrition and supportive services comparable to those provided under title III. However, neither the title nor the regulations are as restirctive as title III with the result that tribes have great flexibility in developing programs that are based on traditional cultural values and reflect local needs and strengths.

In the first year of operation, with a congressional appropriation of $6 million for title VI, 85 tribal organizations were funded. During that year, 1981, Congress enacted several provisions in the act which allowed additional flexibility to tribal organizations in administering their programs, such as dropping a specific age critieria for service eligibility.

In fiscal year 1982, and 1983, 83 tribal organizations were funded with an appropriation of $5,735,000. We are currently accepting applications for fiscal year 1984. The President has asked Congress to increase the appropriation for title VI in 1985 to $7,500,000 but the actual amount for funding will not be known until an appropriation is signed into law. AOA anticipates funding 20 to 25 new projects in amounts ranging from $50,000 to $100,000, contingent upon final appropriation of the amount requested in the fiscal year 1985 budget.

What services are being provided under title VI? In a national evaluation compiled in October 1983 by the Native American Consultants, Inc. [NACI], it was found that all grantees provided nutrition and information and referral services. Meals were usually provided 5 days a week, although some projects chose to do so less frequently in order to encompass a larger geographic area. Home-delivered meals have made title VI services accessible to Indian elders who would otherwise be excluded due to poor health, responsibility for the care of grandchildren or lack of transportation. Congregate meals have also increased the social contacts of the participants thus reducing isolation and loneliness.

Since the 1981 amendments to the act, tribes have devoted 65 percent of the title VI funds to congregate and home-delivered meals. The title VI service reports for the year ending September 30, 1982, showed 1 million congregate meals from all funding sources were provided to 12,000 home-delivered meals to about 5,000 older Indians and their spouses. In addition, a total of about 13,000 persons received supportive services.

A variety of optional supportive services were provided under title VI, transportation being one of the most frequently provided service. A few programs provide in-home services, such as wood chopping, hauling of water, and/or fuel, and other chores. Some tribal organizations provide ombudsman services. However, NACI specifically cited long-term care services as a major gap in essential services for the Indian elderly.

I shall present later a few initiatives undertaken by the Administration on Aging to address the need when I discuss the title IV program. Before I do this, however, I would like to talk briefly about the title III program.

Many of you are familiar with the network of State and area agencies under title III of the act. The broad objectives of the act and their specific provisions are implemented primarily through a national network on aging consisting of the Administration on Aging at the Federal level, State and area agencies on aging, Indian tribes, and the extended network which includes the agencies and organizations providing direct services at the community level to older individuals.

Under title III, the Administration on Aging annually awards grants to the States to foster the development of comprehensive and coordinated service systems to serve older individuals, to:

(1) Secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services;
(2) Remove individual and social barriers to economic and personal independence for older individuals; and
(3) Provide a continuum of care for the vulnerable elderly.

Fifty-seven State and territorial agencies receive support under title III of the act. These agencies are organizationally located in State governments, territories, and other U.S. jurisdictions, either as independent agencies reporting directly to the Governor, or as components of larger human service agencies.

States have designated approximately 662 area agencies on aging to plan and administer title III programs. An area agency on aging may be a public or private organization, an Indian tribe, or a substate regional body. Area agencies have the major responsibility for the administration of funds for title III-B supportive services and title III-C nutrition services. Area agencies are responsible for providing technical assistance to, and monitoring the effective and efficiency of, their respective service provides. Seven Indian tribes are area agencies on aging.

The reports from the State and area agencies for title III for the year ending September 30, 1983, showed an estimated number of 9 million persons receiving supportive services of whom 40,000 were American Indians or Alaskan Natives. There were 145 million congregate meals served, from all funding sources, to 3 million persons, of whom 38,000 were American Indians or Alaskan Natives. In home-delivered meals, there were 58 million meals to 589,000 persons, of whom 7,000 were American Indians or Alaskan Natives. The Indians served under title III are in addition to those served under title VI.

We are encouraging State and area agencies to serve more minorities through our national minority initiative, under which the National Indian Council on Aging [NICOA] is participating in a series of biregional workshops with State and area agency staff to identify ways of increasing minority participation in title III programs.

AOA's concern about the needs of older Indians is reflected in its research, demonstration, and center programs under title IV of the act. As its major discretionary program effort to address the long-term care needs of the elderly, AOA is currently funding 11 multidisciplinary long-term care gerontology centers across the country.

These centers are designed to build a knowledge base and to disseminate information about long-term care. The centers provide interdisciplinary geriatric/gerontological training of professionals in the fields of health, nursing, social work and other related professionals. The centers also are responsible for developing service models, conducting research and providing assistance to service providers.

Three of the long-term care gerontology centers are conducting special activities relating to the needs and concerns of older Americans. The University of Arizona Center in Tucson has assumed a major role in serving as a national resource for the long-term care needs of older Native Americans. The Arizona center has assumed this role because of the center's unique location in the Southwest which has a high concentration of Native Americans. The Arizona center functions as a national resource for gathering, interpreting, analyzing and disseminating information.

The Arizona center has engaged in a number of activities with several Indian tribes. They have studied aging services and policy development in the Navajo Nation and the effects of relocation on elderly Navajos. The Navajos have traditionally had a strong tribal commitment to provide aging services; however, the study by the Arizona center recommended that the Navajo Nation establish a process for providing a continuum of care for elder Indians.

The Arizona center has completed another study entitled a "Profile of Indian Nursing Homes." This study provides a profile of eight nursing care facilities located on reservation land. Four of these facilities are in Arizona and serve the Papago, Pima, Navajo and Apache Tribes. One facility is located on the Blackfeet Reservation in Montana, one on the Laguna Reservation in New Mexico, one on the Omaha Reservation in Nebraska and the eighth one is in Wisconsin on the Oneida Reservation. The study identifies a number of areas for future exploration of the best approaches for providing long-term care in Indian communities.

Recently, the center completed a study for the Papago Tribe regarding the feasibility of constructing a 50-bed nursing home on the Papago Reservation. The center provided consultation and recommends to the tribe for alternative approaches for meeting long-term care needs.

The center has also conducted several short-term training courses for Indian service providers. Also, the Pascua Yaqui Indian Tribe contracted with the center for the conduct of the evaluation of the tribe's title VI evaluaion in 1982.

The Long-Term Care Gerontology Center at the University of Utah is involved with the Navajo community in southern Utah. They conducted a needs assessment and identified resources available to meet those needs. The center is providing technical assistance to the senior center for further development of its program.

A workshop for elderly caregivers and aging service providers for improving service delivery systems is planned in June. Through assistance provided to the Navajos by the Utah center, community leaders in some of the small towns have banded together to form an association for coordinating efforts. The Utah center is providing materials to form a gerontological library at the medical clinic and at the two schools which serve the area.

The University of Washington Long-Term Care Gerontology Center received an award for $11,000 from the Indian Health Service to develop a geriatric health care model for health paraprofessionals who work in tribal settings. A 3-day symposium is planned for late May for community health representatives from around the country. This session will focus on gerontological training and will result in the development a model training program for paraprofessionals in rural areas.

Also the Washington center is working with the Older Alaskan Commission to design a data base analysis and tracking system. With the establishment of the new data system, the Alaska Commission expects to improve the delivery of relevant services throughout the State which will ultimately result in improved services to Alaskan Native Americans.

During the past several years, the Administration on Aging has funded several other discretionary grant projects related to Indian concerns. In 1976, AOA provided funds for the first National Indian Conference on Aging. A major report prepared by Juana Lyon entitled "Indian Elder, a Forgotten American" was a product of that conference. Since that time AOA has provided continuing financial support to the National Indian Council on Aging [NICOA] to undertake a number of initiatives.

These initiatives include an ongoing needs analysis, resource development and the development of service programs for older Indians.

AOA has funded three other projects involving Indian tribes under title IV. These projects include improvement of the farming business at the Tule River Tribe in Porterville, CA; development of employment opportunities for older Indians at the Ketchikan Indian Corp. in Alaska; and improvement of health services to the Confederated Tribes of Chehalis, Oakville, WA. A contract for the evaluation of the title VI program was awarded to the Native American Consultants, Inc. This report was completed in October 1983.

In closing, I would like to point out a few facts unique to Indian communities which must be considered in developing long-term care services for older Indians. These factors include the geographic distribution of population, the availability of informal caregivers, the number and location of institutional facilities, and the unique cultural needs of older Indians.

The elderly Indian population is generally dispersed throughout vast geographic and usually very rural areas. Consequently, it is expensive to provide needed services to the elderly Indians. As in the case of other groups, the role of the middle-aged Indian woman caregiver is diminishing. Many middle-aged women now work and are unable to provide traditional care for their elders.

Current financing systems for meeting the cost of long-term care tend to favor placement of the Indian elderly persons in a long-term care facility which is financially expensive and often less than satisfactory because of institutional inability to attend to cultural needs.

I want to thank you for this opportunity to share with you some of the activities and experiences we at the Administration on Aging have had in the programs funded under the Older Americans Act. I would be glad to answer any questions you have. Thank you.

The **Chairman**. Thank you very much.

I would like to compliment the panel for very excellent testimony. We do have some questions.

I would like to direct the first question to Mr. Graves. Mr. Graves, you told the committee that there were from 300 to 400 Indians that lost SSI benefits. Will you explain why they lost them, and what remedy do you recommend?

Mr. **Graves**. The Bureau General Assistance Program has a component of service where it can purchase residential care for Indians. Often that individual requiring residential care is an SSI recipient. The cost of that care is considered as income under SSI.

The **Chairman**. In other words, the amount of moneys made available through the assistance program are counted as income?

Mr. **Graves**. Yes, sir.

The **Chairman**. And as they are counted as income, that will not make it possible for that individual to qualify under SSI?

Mr. **Graves**. Correct. Basically, each time they go through their quarterly review and they consider that income, gradually the Bureau phases it in until it is paying the full cost of care.

The **Chairman**. Is it your opinion that it should not be counted as income?

Mr. **Graves**. Yes, sir, I agree with that statement that it should not. In many respects the Bureau's general assistance payment is very similar to the public assistance payment that the State is making elsewhere. So in that sense we would like to be treated much the same as the State is able to supplement SSI.

The **Chairman**. Well, has an estimate ever been made as to what additional funding would be necessary if that would take place?

Mr. **Graves**. I can only speak to our Arizona experience. But to our program—this is roughly $300,000 a year. This would be excluding the Navajo population which comes under another service unit of the Bureau.

The **Chairman**. Well, I ask this question, of course, only with regard to Arizona. I realize you do not represent the entire Nation.

The committee will make available questions in writing to each member of the panel, and these questions, of course, will be directed to the Arizona problem and not the national problem.

But we do have some questions with regard to the national problem.

I would like to go on with Mr. McCarthy. Mr. McCarthy, you stated that the Administration on Aging is funding 11 long-term care gerontology centers. I know for a fact the administration has only requested funding of $5 million for title IV in fiscal 1985. Now, how do you plan to continue these centers with only $5 million for the entire title IV program?

Mr. **McCarthy**. I don't really know how we will be able to continue the program at the present level.

The CHAIRMAN. The truth of the matter is that the funding has been reduced substantially. The recommendation made by the administration for this particular purpose the year before last was $5 million. It was my amendment that restored the funding to $22 million. Again last year the administration again recommended only $5 million. I again proposed the amendment that increased it to $22 million. We don't know what is going to happen in the budget of 1985. What we do know is that the Senate has taken certain actions that agree with the administration's recommendation.

Now, as you know, last year we submitted a budget, that is, the Committee on Appropriations, but particularly the Subcommittee on HHS, submitted a budget that was $2.3 billion more than the President had recommended, and immediately the President said, "I will veto that piece of legislation." I am not going to bother you with what took place after that. The truth of the matter is that he did veto it.

So my question to you gentlemen is while you have a specific duty to perform, while you know there is a great need for this funding, what are we going to do about the cutbacks? How are we going to prevail upon the administration to pay a little bit more attention to the needs of the elderly in the United States? I think that is a $64 question. But you are experts in the field. Maybe you can tell us how we can do that. Do you have any ideas, Mr. McCarthy?

Mr. MCCARTHY. I have a lot of ideas, Mr. Roybal. I think in terms of long-term care that our investment long-range will save us in the country money. Obviously you are aware in the Congress of the escalating costs of Medicare and Medicaid.

I think an investment in long-term care and a country-based system of long-term care in the end will save money for the budget. But of course I am not in a position to make those decisions. But I would certainly recommend that long-term care funding for community-based systems be a high priority.

The CHAIRMAN. Wouldn't you also recommend that funding for Medicare as a whole should not be reduced? You are working in this field. I just am interested in what your position is with regard to the fiscal problem that we have with Medicare. You know in maybe 3 years, no more than 5 or 6, we will be facing a real fiscal problem with regard to Medicare. The reductions taking place are only compounding those problems.

I am just wondering if there is any suggestion, any recommendation that could be made as to how we could address ourselves to these problems and prevail upon this administration or any administration. How are these people going to pay for it?

For example, the reduction that is now made for this year which already passed the Senate is $6.2 billion. They tell us that is a saving. It is not a saving because the costs remain the same. But someone has to pay. And the ones that have to pay that are the senior citizens. They are the ones that can least afford it.

So I am just seeking some answers. What can be done about a situation like that? Do you have any suggestions, any ideas? We would appreciate if you would volunteer to give them at this time.

Mr. O'HARA. I know the administration's point, of course, is to attempt to deliver hospital care, long-term care, physician services in a more efficient way, so that the amount of expenditures that are put out for these huge entitlement programs is more efficiently used and will not necessitate a reduction in the service to beneficiaries of the programs.

This new DRG system that is in the hospital program under Medicare everybody is hoping will save significant amounts of money and will enable the trust fund not to go dry as soon as it might otherwise.

The Chairman. Mr. McCarthy, I am asking you questions that really should be directed at a national level. However, I would like to ask you a question that directly involves the State of Arizona. Clients receiving title VI money are not eligible for title III; is that correct?

Mr. McCarthy. No, they are eligible for title III. They may receive title VI funding and title III funding.

The Chairman. The recommendation was made this morning that title III and title VI be combined. Will that in any way be helpful?

Mr. McCarthy. Well, perhaps I could give you a little background behind that. When title III came into existence and there was a prioritization, where money flowed to minority elderly and to reservations, we found that as the money came for social services, moneys that were being used from other programs were being taken away.

So the intent of the Administration on Aging has been to keep title VI funding for separate populations so that the title III dollars would not misplace title III dollars that already existed on the reservation. Title III money is administered only through the States, and it is at their decision and their discretion as to how much money of title III they will dispense through area agencies on aging to tribal reservations.

The Chairman. Mr. McCarthy, isn't it true that, taking a nutrition program for example, if that nutrition program is funded under title III it cannot simultaneously receive money from title VI?

Mr. McCarthy. It can serve the same population. A reservation can take title III money from the State or the area agency on aging and fund certain areas of its reservation. It must use the title VI for a separate population on the reservation.

The Chairman. But at the same time it cannot take moneys from title III?

Mr. McCarthy. The State could make that decision if it wished to.

The Chairman. Does the State make that decision?

Mr. McCarthy. Some have.

The Chairman. My understanding is that they choose not to do that, that if they fund something under one title, that they will not simultaneously take money from title VI. Is that what is done in this State?

Mr. McCarthy. In this State, the State has taken the title III—it proceeds on the basis of the percentage of the total national population over 60, and has shared it with the reservations in the State to the tune of a little over 16 percent of their title III allotment goes to reservations which have on them about 2½ percent of the population over 60 years of age. I am proud of the record of this State, and I think the tribal governments also see that as a very positive contribution.

There are about eight Indian reservations in this State that also receive title VI funds. And I can understand the concern of the presenters on the panel this morning. It can cause them some administrative headaches.

I think the intent, though, was to make sure if a tribal reservation received title VI funds that the title III funds would not dry up and disappear and be taken away by State government. It hasn't happened in Arizona, but it has happened in other places.

The CHAIRMAN. Mr. McCarthy, I am pleased to know that your administration and the State of Arizona does not penalize those individuals that receive this type of care. If money is taken from title III, they can also benefit under title VI. But there are States that do not. And that is one of the problems that we have throughout the country.

Now, one other thing with regard to Medicare. You stated that a limited amount of care provided under Medicare was traditionally considered long-term care facilities. How limited is that?

Mr. O'HARA. That refers to the skilled nursing facility benefit under Medicare. Approximately 4 percent of the total Medicare dollar goes to the skilled nursing facility. If you recall, the purpose of that skilled nursing facility benefit was to encourage patients who were ready to leave a hospital to go to a less expensive institution. And there is a limit of 100 days of care under that Medicare provision. In actual fact, our experience is that because it requires skilled nursing care or physical therapy, some other therapy, the average covered stay is only about 20 days.

The CHAIRMAN. Does that also not include—the size of the skilled nursing facility, does it not also include hospices?

Mr. O'HARA. Yes.

The CHAIRMAN. How extensive is the hospice care?

Mr. O'HARA. The hospice program is just beginning, just started October 1, and actually the number of facilities that have been certified has been very limited so far because the amount payable to hospices has been very severely restricted.

The hospices are finding it difficult to make the necessary arrangements with hospitals and other providers to assure that they can stay within the amount that is allocated, some $6,500 average payment per patient is what they have to do. And we are talking about patients who are estimated to have less than 6 months of life in the hospice. If the patient requires more than $6,500 worth of care, that additional cost is on the hospice rather than the Medicare Program.

The CHAIRMAN. I asked that question because I put in the money for the first hospice facility several years ago. And I have been following the program. I realize additional amounts will be made as the need continues. I feel this is going to be a need that is going to continue. Do you agree?

Mr. O'HARA. I agree.

The CHAIRMAN. Thank you.

The Chair recognizes Mr. McCain.

Mr. McCain. Thank you, Mr. Chairman. I also share your opinion on hospices, because I find it one of the ways that we can reduce the terrible costs, skyrocketing costs of health care. Also, everyone I have talked to who has had anyone involved in the hospice program is deeply satisfied with the other aspects of it.

Since we talked a little bit about the cost of health care and budget cuts, I think maybe we ought to also add to this discussion the fact that the largest, single, fastest growing part of the Federal budget is not defense, but the cost of Medicare, which directly reflects the dramatic increase in the costs of health in this country. Unfortunately, we happen to live in a State where it is worse. Last year the cost of health care in America went up 9.5 percent; in Arizona it was up 19.9 percent.

Not only do we have a problem of budget cuts, but we are faced with the bankruptcy of the Medicare Trust Fund, and the question is not whether it is going to take place, it is a question of when. Congress also has an obligation on this issue.

I was interested, in case the witnesses here did not know it, when the Congress on a voice vote about 1 month ago turned down the requirement proposed by Mr. Rostenkowski for physicians' full assignment for Medicare. So we not only are facing budget-cut problems, but we are also facing serious and severe problems with the rising cost of health care.

Hospices are I think one way to hold down costs. Mr. McCarthy mentioned the hospice and other programs—DRG's and others—which are efforts to bring these costs under control.

We do have another panel and time is short. I would like you to make your answers as brief as possible.

Mr. McCarthy, the House amendments to the Older Americans Act changed from 75 to 60 the minimum number available needed by a tribe to qualify for title VI funding. How many tribes in Arizona would now be eligible because of this change?

Mr. McCarthy. About five more tribes would be eligible.

Mr. McCain. Which would still leave a large number of tribes ineligible. I think we have to look to make more tribes eligible; would you agree with that?

Mr. McCarthy. Yes, I would agree.

Mr. McCain. Dr. Vanderwagon, is it true that IHS is part of the so-called Indian Elders Initiative Task Force?

Mr. Vanderwagon. Yes.

Mr. McCain. Would you expand a bit on what that group does, if it has any specific goals it is trying to obtain, and whether it will be reporting to Congress on any proposals.

Mr. Vanderwagon. I will take the last part of that first. I don't know if they plan to report at this time to Congress. The direction that that group is going,and I have only participated in two meetings to date so I can only comment about those two sessions. But the direction the group is going is an attempt to expand the understanding and awareness of some of the approaches that can be taken, particularly with regard to elderly nutrition problems, pharmacy problems, with accidents, injury and stress. These are some of the types of initiatives toward prevention that the group is trying to stress.

They have sent out a number of educational materials not only to the Indian Health Service facilities, but to tribes as well. Right now that is the bulk of the activity that I can report on.

Mr. McCAIN. I would like to ask Mr. Graves and Mr. Vanderwagon, does the Administration on Aging have any ongoing coordinated relationship with the Bureau of Indian Affairs, which spends almost 10 percent of its budget on social services for Indians?

Mr. GRAVES. Not that I know of.

Mr. McCAIN. To all of the witnesses: Arizona's AHCCCS Program does not provide long-term care for anyone. What effect does this gap in State assistance have on the budgets and the programs of your respective agencies as providers for types of long-term care to Indians?

Mr. GRAVES. The program that the Bureau provides for adult institutional care is almost exclusively because of the lack of these programs in Arizona.

Mr. McCAIN. But there are other States in which Medicaid funding does provide long term?

Mr. GRAVES. And essentially we have no program of this type.

Mr. VANDERWAGON. I talked with Mr. Butler, who is the Washington social service head of the BIA, discussed these problems. What he shared with me were these statistics. That with BIA social service activity in the State of Arizona, approximately 500 patients came under custodial and domiciliary care within the State of Arizona. For all the rest of BIA's domain it was a total of 45 cases.

Mr. McCAIN. About how much money?

Mr. VANDERWAGON. We did not discuss dollar figures. There is a significant difference, clearly, in Arizona. For the Health Service in this State, we have been averaging 75 to 80 individuals in skilled nursing or intermediate care facilities over the last 2 or 3 years and it is costing us between $750,000 and $1 million a year to support these individuals in these facilities. That is the impact it has had on us.

Mr. O'HARA. In terms of the Medicaid budget, there was a savings on the Federal side because basically Medicaid, there is a sharing of costs between the States and the Federal Government for long-term care as well as other care for Medicaid. The sharing is 60 percent Federal and 40 percent State. So the failure of the State to select coverage of long-term care under Medicaid has been a significant savings to the Medicaid budget, the amount is unestimated at this time.

Mr. McCARTHY. As far as our program in the State, it at least put a tremendous burn on the programs to move very slowly into the area of community-based long-term care, but without anywhere near the resources to do so.

Mr. McCAIN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

I would like to ask a final question of each one of the participants. And that is what and who should the various Federal, State and local agencies begin to coordinate their resources to insure the availability of long-term care facilities within the Indian community?

We were told this morning that the lack of coordination is one of the problems that weighs most heavily upon the health delivery system. I am asking you now, how can we start to cooordinate these activities so that more efficiency can be brought about?

Mr. Graves. The heart of the matter is working with the established tribal governments. The accountability of those tribal governments, and many of these tribes are small but they are all governments. The accountability to the proliferation of these funding sources—and I would say that our accountabiity for those expenditures of Federal dollars goes back to the Congress, so many dollars for housing comes down, Congress wants to know how many dollars are spent for housing.

And if the tribe had the ability to apply for funds and for some way these could be reprogrammed such that it meets those objectives authorized by the Congress as the tribe develops their plans for it, and the funding agencies contribute—because they all have identified moneys there—this is the best answer I can talk to you about in terms of coordination.

The Chairman. Mr. Vanderwagon, the various tribe representatives this morning told us that, yes, there is a problem with regard to the tribes. They said there is also a problem with regard to the various agencies. There seems to be no coordination there. The question is, how can we bring about this coordination that is most necessary in order to get the delivery system to the recipient?

Mr. Vanderwagon. Well, Mr. Chairman, I think this process does a lot to make people aware of that as a problem. I think in that operation within our programs we have recognized the paucity of comprehensive data that allows us to really get a handle on the true scope. Certainly in the Phoenix area for instance the BIA and—have worked together on some issues. I think that sharing has been profitable.

I don't have a clear answer other than I think the kind of activity that is initiated with the AOA, INA, IHS working together on some issues, I think that is a beginning. Certainly BIA and the Indian Health Service has a strong working relationship.

The Chairman. You don't discount that and say it is impossible; you say it is possible?

Mr. Vanderwagon. With difficulties, certainly. But possible.

The Chairman. If there were no difficulty, there wouldn't be any joy in attempting the coordination.

Mr. O'Hara.

Mr. O'Hara. Of course Medicare and Medicaid is primarily a funding source and I think probably in terms of coordination we certainly could work with the various constituent agencies within HHS and talk about how they may better propose ways of taking advantage of the available Medicaid and Medicare Program.

I know, for example, there is a Senate bill that talks about making payments under Medicaid and Medicare possible for ESRD payments and health payments under Medicare. So it would seem like that is the kind of coordination that should be very possible in HHS, I would think.

The Chairman. Mr. McCarthy.

Mr. McCarthy. In response to that, I would like to answer on two levels. One is that, for instance, in the State of Arizona we have two out of the eight area agencies on aging are controlled and managed by the tribes themselves. So we have the mechanism. And by statute, those two agencies are supposed to be the focal point for all service rendered to elderly on the reservations. In fact, by law they only have management and control over the title III and the title VI funds they receive. Any other Federal source, any State source, can bypass them. As long as we have that kind of a system in existence, we are going to have lack of coordination.

Second, what is most needed in the area of long-term care for elderly people is a case manager or a gatekeeper that can actually move resources quickly and readily to the needs of the elderly person. When you are dealing with that population, you are dealing with a population that has ups and downs very, very quickly in their health status and there is a need for promptness. We don't have that capacity at the moment.

The CHAIRMAN. Would an Indian Chair in the Department of Aging help solve the problem?

Mr. MCCARTHY. I think it would be a partial step. I don't think it would solve the problem.

The CHAIRMAN. This recommendation was made this morning. In fact, the various tribes made quite a few recommendations. I asked them if it would not be possible for those testifying to get together, different tribes, and come back and make no more than 10 recommendations to this committee. They were gone about an hour and a half, and came back, with eight recommendations, which indicates to me that we can try to do something. And those recommendations will be reviewed by this committee.

What I was trying to get is, at least hope that the coordination process can take place. And I think I got that hope from each and every one of you. I thank you very much. I thank you gentlemen for very excellent testimony.

The CHAIRMAN. The next and final panelist is Tammy Sixkiller and Larry Curley. Ms. Sixkiller.

[Prepared statement of Larry Curley may be found in the appendix.]

## PANEL CONSISTING OF TAMMY SIXKILLER, NATIONAL INDIAN COUNCIL ON AGING; AND LARRY CURLEY, EXECUTIVE DIRECTOR, LAGUNA RAINBOW CORP.

Ms. SIXKILLER. I am very happy to be here. I am sorry that Mr. Elgin is not able to be here. Therefore I would like to make a very short statement. We will have a more comprehensive statement later.

The CHAIRMAN. Thank you.

You may proceed in any manner you may desire.

Mr. CURLEY. Mr. Chairman, members of the distinguished panel, it is a pleasure to be here. You have my written statement. For the sake of time I will just get right down to the issues I have discussed in my presentation.

The Indian community in this country has increased, as you know, by 71 percent between 1970 and 1980. I am currently the executive director of the Laguna Rainbow Corp. for the Pueblo of Laguna. It is a multipurpose organization that handles a variety of funding sources among which is Medicaid. We also receive funding under the Housing Sources Act. We receive funding under the title

VI program. We also receive funding from the U.S. Department of Agriculture Commodities Program. So in a sense we do cover the entire continuum care spectrum that people have alluded to this morning.

We have encountered some problems which I believe should be discussed.

Part of the requirements and part of the recommendations that I see in the area of long-term care, is I believe, that Congress should enable the development and passage of legislation that will make Medicaid/Medicare funding directly to Indian tribes.

We believe, No. 1, that Indian tribes should deal directly with the Federal Government rather than through the State governments and that this would strengthen that concept.

We believe also that this will allow tribes similar to those in Arizona who do not have Medicaid Programs to benefit directly from the Medicaid program.

We also believe that it is very possible that these funds could be channeled through the Indian Health Service and subsequently to the area offices.

The problems that we have encountered in this particular area in terms of Medicaid has been, I think, that this particular mechanism would solve a lot of the problems in the area of cost reimbursement formulas we believe are inadequate to meet the expensive cost of providing the care in isolated areas, particularly our nursing home on the Laguna Reservation is encountering.

If that is not a way to go, I believe at this particular time Medicaid/Medicare has basically three categories of care—skilled nursing, intermediate care, intermediate care for the mentally retarded. I believe another method would be the development of a fourth category, intermediate care facilities, Indian reservations.

We seem to encounter problems also with definitions, and a consistent definition of skilled nursing, intermediate care, custodial care. Some of the Federal agencies use different definitions.

I also believe that within the Medicaid and Medicare Program, that the programs that are there are built upon the non-Indian experience. Therefore, the non-Indian definitions are made to apply to older Indians in the last years of their lives. They have been Indians for over 60 or 70 years, and in their last few months of life we are making them turn into non-Indians.

In that particular specific instance, for example, we have medicine men that we have traditionally used. Some of our elderly still utilize those services. However, Medicaid does not recognize medicine men as physicians. We believe they are.

I hope that as we go along, if that does happen, that we need not begin to certify and license medicine men, either.

I believe there is a comprehensive continuum of care strategy we are pursuing. In our experience there are Indian health facilities in the country that are half vacant.

In these instances, as I indicated, we have community-based services, congregate housing, intermediate care. And when our elderly people get worse, we would like to be able to use these half-empty hospitals, IHS facilities, and utilize the concept of swing beds, so that we can fulfill the skilled nursing needs of our Indian elderly. However, we have been told by Indian Health Service, No. 1, that

Congress has never specifically mandated that Indian Health Service get involved in the long-term care industry. Second, they have indicated that there is lack of funding to begin new initiatives.

Another issue in terms of just the Medicaid Program that we are encountering is that our realities are quite different. For example, death is such an interesting concept. In our community, death is viewed differently. And yet in the non-Indian community, the standards for death is when the heart stops or when the brain waves begin to cease. In our community it is a little bit different. Yet Medicaid reimburses us on a bed-occupied basis. We believe that our elderly people when they pass away still occupy those beds and we believe that we should be reimbursed for the days that our elderly are still there, although in your reality they are not there.

Another issue that we have encountered is that in the Medicaid Program the State Medicaid Program imposes its pharmacy requirements onto such facilities in the Indian Health Service. The Indian Health Service is a Federal agency.

I do not understand how State regulations can supersede Federal regulations. And in the process of that, we end up having to buy pharmacy supplies from contractors that cost the State money, they are telling us that we have to go with the private contractor, and that we should try to impose State Medicaid requirements and pharmacy procedures on the Indian Health Service.

I think that in the past 2 days I have heard Indian people refer again and again to the need of long-term care facilities. I believe it is needed. However, the funding isn't there. Maybe the time is right to begin to reconsider an Indian Hill-Burton Act.

In order to staff these nursing homes across the country we find there are no professionals to effectively manage these systems. I find for example that there are only three Indian people in the United States that have been trained to manage nursing homes. So that I began to look at the Administration on Aging with its $5 million and wonder how they are going to come up with a cadre of professionally trained people to do that.

Still in the area of nursing homes, I would believe that maybe one of the considerations should be the development of regional long-term care centers rather than long-term care centers for each and every tribe.

I believe that one of the things we need to look at is to begin to also mandate not only the Indian Health Service but the Bureau of Indian Affairs to become involved in the long-term care business.

I think another area in the same area is that Indian Health Service physicians at times determine that our elderly people deserve or require skilled nursing or intermediate care. Once that determination is made, it is sent to the local PSRO, the Professional Standards Review Organization.

The Professional Standards Review Organization denies that that individual requires that level of care—I believe the Indian Health Service has a responsibility, since it was their staff people who made the recommendation that this individual needs intermediate care, that the Indian Health Service needs to take its legal body and support the position of it physicians.

I believe that one of the things that I have heard in the past 2 days is that there seems to be a confusion between title III and title VI of the Older Americans Act, which is part of the comprehensive service delivery system. I believe that title VI, since I was so intimately involved in the development of the title VI program, that the title VI program was designed to provide Indian tribes an opportunity to develop their programs without the involvement of State government.

It is much more a service designed to reaffirm the Federal-tribal relationship. And I believe rather than beginning to combine title III and title VI, because title VI is the Indian version of title III, that there needs to be more funding into title VI.

When I heard that the Administration on Aging is asking for $7.5 million and concurrently increasing the number of grantees, I don't know how we can begin to effectively begin to develop those kinds of programs that are designed to keep our elderly people out of nursing homes. I believe that is important.

The variety of Indian tribes across the country have recommended, as stated earlier, that there needs to be an Indian desk within the Administration on Aging, that there needs to be $50 million appropriated in fiscal year 1985, $60 million in 1986, and $70 million in 1987. I don't think that is very much to ask for.

I think that by concentrating on the Older Americans Act, I think that we tend to overlook that there are other social service programs that are not even considered within the context of this particular meeting. Specifically, $2.9 billion is made available every year under the title XX program, under the social services block grants. I believe Indian tribes should be eligible to receive that funding just as title VI, directly from the Federal Government.

In addition, you have heard that in this country today—I would like to mke a correction—there are not eight Indian nursing homes, there are nine, one being in Colville, the Confederated Tribe of Colville. We have a capacity in this country of Indian nursing homes of less than 500. Obviously there are other Indian people off reservations who do not have the protection of the tribe.

In 1978, Congress passed the Indian Child Welfare Act. The Indian Child Welfare Act protects the rights of young children. If a law is good enough for our young people, I believe Congress needs to enact legislation that will protect the rights of our elderly people by passing an Indian Elderly Welfare Act.

I believe, finally, in terms of the coordination issues that we have talked about for most of the morning, that in HHS alone recently that there are more than 40 different definitions of what is an Indian. I think that is just the beginning. I believe that the definitions that are used need to be consistent across all Federal agencies.

I believe that the establishment of an Indian desk within the Office of Management and Budget is also a necessary first step.

In addition, I believe that the Indian Health Service, which is charged with the responsibility of providing health care to our Indian elderly, needs to also develop an Office of Long-term Care within its organization.

In addition, there is always the problem of the definition of elderly. No one is consistent on that either. I know, because under our congregate housing project, elderly is defined as 62 years of age. The Older Americans Act title V program defines elderly at

55. And in the Older Americans Act title VI program it says that any age the tribe determines to be elderly. And under the GPTA Program, elderly is defined as 45. So that there are differences.

Maybe one of the ways that we might want to go at this is beginning to identify those funding sources and beginning to put these into block grant formulas so that Indian tribes receive these directly.

I think in order to do that, we all need to understand the reality of how Congress is, and that may be the first beginning, to get the different committees of both the House and the Senate side, begin to get together and identify those pieces of legislation that benefit elderly Indians and begin to revise and begin to push forward with consolidating a lot of those programs in one fashion or another.

Our elderly people, as you have heard, are living 10 years less than our counterparts. When Social Security was recently talked about, they are now talking about increasing the age requirement to 68. When our elderly people live to be 63, we have effectively subsidized the rest of the population, because most of them will never make it to that age.

For example, the Railroad Retirement Board eligibility to receive pensions, you must work 30 years and you must be 60 years before you begin to collect. And if you happen to be 55 and you have worked 30 years, you have to wait for 5 years before you begin to receive your pensions. And if you happen to find a part-time job, you effectively lose your rights to those pensions. I believe that is something that needs to be looked at, because my people in Laguna, most have worked for the Santa Fe Railroad all their lives, and I would hate to see that kind of a system imposed upon our elderly people.

Mr. Chairman, this concludes my remarks. I appreciate the opportunity to talk with you and discuss the issues that I have just related.

I hope that the time that we have spent in this 105-degree weather was for more than just losing weight, that I can go back to my people and indicate to them that I met with you, and that I talked with you, and that you heard, you have listened, and that you will help.

One final recommendation, Mr. Chairman.

I hope a year from now that we can have another congressional hearing like this to find out where have we been. I hope that we can do that.

Thank you.

The **Chairman**. Thank you. Mr. McCain.

Mr. **McCain**. Thank you very much, Mr. Chairman.

I was doing a little homework last night. The statement was made:

> It is clear that a comprehensive approach to aging services provision needs to be developed and implemented. National Indian aging policy is a must and should not be considered an exclusive responsibility of the Administration on Aging but rather a responsibility that all federal departments need to share, particularly those agencies with primary responsibility for services to Indian people.

Do you recognize those words?

Mr. **Curley**. They are mine.

Mr. McCain. Back in 1981. I wonder if you have seen any progress since you made those very important statements to the Select Committee on Indian Affairs of the Senate about 3 years ago?

Mr. Curley. I have not seen that much improvement. As a matter of fact, I think conditions have worsened. When title VI of the Older Americans Act was passed in 1978 and implemented in 1981, there was a $6 million approach. It has steadily decreased. Now we have at the same time the elderly population in the United States has increased and yet we are expected to do more for more people with less money.

I find, for example, that our elder people have to do without what is referred to as elective surgery and they end up in a nursing home suffering from delayed surgical procedures that could have prevented that.

Mr. McCain. Thank you very much, Mr. Curley.

Mr. Chairman, I have to go catch an airplane. I would like to again express appreciation of all of us for your taking time from one of the busiest schedules of any Congressman to meet in Arizona with us. I appreciate it very much.

The Chairman. Thank you, Mr. McCain.

Ladies and gentlemen, you probably notice the other members of the committee have also left. They did so because they have to catch an airplane to attend other duties. We appreciate the fact that they were here. They listened. But above all, the recommendations that have been made will be submitted to them. We have various recommendations. In fact, eight in total. And I would like to discuss with Mr. Curley just one of these recommendations, because the time is already gone, and we will have to adjourn momentarily.

I would like to discuss this one particular recommendation with Mr. Curley, which is one made by the various representatives of the Indian nations that were here this morning. One of those recommendations reads with regard to titles III and VI, you take the position that they should not be combined.

I would like to read the language of their recommendation which, in my opinion, leaves it open. And I think they are wise in doing that. And this is what they say: Revise regulations to allow title III and title VI to be coordinated. They did not use the word to be combined. Do you think that both titles III and VI can be coordinated, so that sufficient funding is made available to title VI and of course whatever is needed for title III—in a recommendation made by both the House and Senate?

Mr. Curley. I feel, Mr. Chairman, that in this particular point in time, I think due to the lack of resources, the lack of title VI programs, I think Indian tribes are happy to use the title III funds in addition to the title VI moneys that they might be receiving. I believe, however, in the long run I think if it was up to the Indian tribes and their preference, and the ideal situation, if you were to ask them whether they would prefer to deal with the title III program through the State program or would they rather deal with the Federal Government and the Administration on Aging, I believe their preference would be the Administration on Aging, let's not deal with State governments.

The Chairman. Yes, I firmly believe it is the desire of the Indian community to deal not necessarily directly with the States, but to deal with the Federal Government. In this particular instance, I believe that a great deal can be done to reach a particular situation where your negotiations are directly with the Government.

Now, as we make our recommendations, I will be writing recommendations that will affect the nursing homes. I am not an expert in that field. In fact, I am not an expert in any field. But I am interested. If I make some recommendations in writing and submit them to you, will you get together with the other two well-trained nursing home administrators, review those recommendations and send back to me your recommendations with regard to the subject matter?

Mr. Curley. I would be more than happy, Mr. Chairman.

The Chairman. I ask that because you said a little while ago that maybe a year from now or so we can sit down and find out where we have been. We are not going to go any place if we don't coordinate our activities, if we don't work together. We in Washington have so many duties sometimes that we don't know whether we are coming or going. But if we zero in on a particular problem, as I intend to do with the hearing today, I think that we can accomplish something.

I want to express my appreciation to you for agreeing to serve in that capacity. And maybe together a year from now we can sit down and say, "You know, we did it."

Mr. Curley. I would appreciate that.

The Chairman. May I thank you and Ms. Sixkiller, thank you for your testimony. I would like to give Ms. Sixkiller the last word.

Ms. Sixkiller. In recommendations, I would like to recommend that with regard to title VI, that the off-reservation people be included. I am a supervisor for a senior citizens center in Phoenix. We serve the Indian elderly in metropolitan Phoenix. We would like to be included under title VI.

The Chairman. Under titles III and VI?

Ms. Sixkiller. As well.

The Chairman. I agree with that. We will no doubt be getting in touch with you also. May I thank both of you for your testimony, and thank the audience for being so patient.

I would like to thank those who made possible the use of this room. Those responsible: Debbie Monahan, Bob Barba, Diane Wasson, Nancy Humble, John Williams, and Carol Cullinan. It takes a lot of effort to put on a hearing of this kind. If we don't have the cooperation of the local community, we cannot hold such a hearing. In this instance you can see the university has been most responsive, that the personnel has been appointed to do certain jobs, that they have done their jobs well. I also thank the University of Arizona for their cooperation, thank the witnesses, and above all thank the people that are here who heard the testimony. We will do everything we possibly can to comply with some of the recommendations that can be made.

The meeting is now adjourned.

[Whereupon, at 3:30 p.m., the hearing was adjourned.]

# APPENDIX

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## FRIDAY, MAY 25, 1984

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### ADDITIONAL MATERIAL SUBMITTED FOR THE HEARING RECORD

RESOLUTION NO. 84-29XB

**[illegible]TION OF THE OGLALA SIOUX TRIBAL EXECUTIVE COMMITTEE**
**OF THE OGLALA SIOUX TRIBE**
**(An Unincorporated Tribe)**

**RESOLUTION TO SUBMIT RECOMMENDATIONS TO THE HOUSE SELECT COMMITTEE ON AGING.**

WHEREAS, the Oglala Sioux Elderly from Pine Ridge, South Dakota wish to avail themselves of the opportunity extended by the House Select Committee on Aging in expressing tribal needs and recommendations, and

WHEREAS, the Oglala Sioux Elderly have long recognized the inadequacies and critical shortages of funds and facilities in trying to meet the overwhelming needs of its own elderly people.

NOW THEREFORE BE IT RESOLVED, that the following recommendations be submitted as a part of the record of the House Select Committee on Aging in the hope that these tribal appeals will be forwarded to all representatives of the Federal government responsible for meeting these needs:

1. In responding to the lack of sufficient swing beds, we request additional funds from the Federal government for one skilled nursing facility. At present, we are deprived of a nursing home on the Pine Ridge Reservation for 150 Indian people who are placed in five different states. It costs more to have them transported to and from locations, when it could easily be avoided by having a nursing home built in the immediate area. Our Elderly Indians are diminishing once removed from familiar environment. We need the support for more social, cultural and recreational activities.

2. In our attempts to strengthen the emotional needs of our elderly, most of whom live in isolation and far removed from the benefits of family integration and community living, we strongly recommend having expansion of federal funds for Title VI, Foster Grandparent Program and Transportation on the Pine Ridge Reservation through Federal programs to enlighten the lives of the Elderly.

3. In providing for adequate health care for our elderly and in order to meet the standards of Medicare and Medicaid to all our First American Elderly, we demand that added Federal dollars, staff facilities and equipment be provided for not less that two years for:

   a. improved payment of claims;
   b. administrative allowances;
   c. adequate eye, dental, ear, and general care;
   d. emergency medical needs;
   e. Community Health Representatives

4. We further appeal to the Select Committee on Aging that in carrying out all of our recommendations, we would like to be kept informed of the progress of the proposed changes to be adopted.

CERTIFICATION

I, as undersigned, Secretary of the Executive Committee of the Oglala Sioux Tribe, hereby certify that this resolution was adopted by the vote of: 4 for; 0 against; and 0 not voting, during a SPECIAL Session held on the 23 day of MAY, 1984.

Eileen Iron Cloud
EILEEN H. IRON CLOUD
Secretary
Oglala Sioux Tribe

A-T-T-E-S-T:

John W. Steele
JOHN STEELE
Vice-President
Oglala Sioux Tribe

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## STATEMENT OF VINCENTI PEDRO, SR., GOVERNOR OF THE PUEBLO OF LAGUNA, BEFORE THE SELECT COMMITTEE ON AGING, MAY 25, 1984

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Good Morning, Mr. Chairman and members of the Committee my name is Vincenti Pdero, Sr and I am the Governor of the Pueblo of Laguna. It gives me great pleasure to be invited to discuss with you the concerns of our Laguna People regarding the services available to our elderly. Although I do not speak on behalf our Indian elderly in New Mexico, I am sure that most will agree with the issues and statements I am presenting. I believe, as the spokesman for my community, that this hearing regarding the subject is long overdue and I wish to take this opportunity to thank all of you for initiating and implementing this hearing.

We, in the pueblo of Laguna, have long felt that our elderly represent the best and cherished values of the Laguna People. As late as the early 1970's, we began to develop plans to ensure that our elderly receive services that would enable them to live out the twilight of their lives in dignity and in a manner that reflects concurrently, traditional and progressive values. We have sought to incorporate these concepts into the programs we have developed on the Pueblo of Laguna. We have done this for the elderly by developing community-based services for our elderly and at the same time built an institutional facility to respond to the institutional needs of our elderly population.

There are 675 elderly age 60 and over in the Pueblo of Laguna. Of these, 5% are in the institutional setting. As our elderly grow even older; as the quality of our economic situation worsens; as more of our young seek employment off the reservation; and as our off-reservation Lagunas return to their communities..... How then do we begin to meet these needs? Where do we find the resources necessary to implement services to meet both the minimal and necessary services that our elderly look to us as tribal leaders, for? Especially when the federal government has become as dry with its financial participation as day old fry bread?

WE ARE AT THE CROSSROADS, LADIES AND GENTLEMEN, OF CREATING A BETTER TOMORROW FOR OUR ELDERLY PEOPLE OR CREATING A TOMORROW WITHOUT HOPE. THIS HEARING IS TIMELY AND IT IS NEEDED. THE INDIAN ELDERLY OF THIS COUNTRY HAS GROWN BY 71% BETWEEN 1970 AND 1980; OR FROM APPROXIMATELY 64,000 TO 109,000. BY 1990, THAT POPULATION WILL DOUBLE- AND IN DOUBLING, THE NEED FOR BOTH INSTITUTIONAL AND COMMUNITY BASED SERVICES WILL ALSO DOUBLE.

WE NEED TO BEGIN NOW TO IDENTLFY THOSE OBSTACLES THAT IMPEDE THE DEVELOPMENT AT COMPREHENSIVE AND COORDINATED SERVICES FOR OUR NATION'S INDIAN ELDERLY. WE NEED NOT WAIT UNTIL THE SITUATION IS AT A CRISIS LEVEL TO RESPOND AND EXPLORE NEW IDEAS. OUR ELDERLY DO NOT HAVE THE LUXURY OF TIME TO WAIT... THEY DIDN'T WAIT WHEN THEY WERE OUR LEADERS TO MAKE DECISIONS THAT BENEFITTED OUR RESPECTIVE COMMUNITIES. WE AS LEADERS, AND YOU AS THE MORAL AND LEGAL CONSCIENCE OF THIS COUNTRY, CANNOT WAIT.

AS I HAVE INDICATED EARLIER, THE HEARING IS TIMELY AND NEEDED. SINCE THE 1971 WHITE HOUSE CONFERENCE ON AGING, WE HAVE EXPRESSED THESE CONCERNS. WE EXPRESS THESE CONCERNS AGAIN; HOWEVER, THE SENSE OF URGENCY WITH WHICH WE COME BEFORE YOU TODAY, UNDERLINES THE CRITICAL NATURE OF OUR CONCERNS REGARDING THESE ISSUES.

I AND THE TRIBAL COUNCIL OF THE PUEBLO OF LAGUNA, APPLAUD THE COMMITMENT AND THE ACCOMPLISHMENTS OF THE SELECT COMMITTEE ON AGING. YOUR FORESIGHT IN IDENTIFYING THE "INDIAN" ISSUE AS WORTHY OF A HEARING IS GREATLY APPRECIATED AND I BELIEVE, PRESENTS A CHALLENGE TO AGING PUBLIC POLICY. IT IS A CHALLENGE THAT WILL TEST OUR LEGAL AND MORAL RESOLVE AS A NATION.

WE AT THE PUEBLO OF LAGUNA STAND READY TO ASSIST YOU IN ADDRESSING THESE CHALLENGES. WE THANK YOU ON BEHALF OUR ELDERLY FOR THE OPPORTUNITY TO HAVE THIS DISCUSSION AND LET ME FURTHER INVITE YOU TO VISIT OUR COMMUNUNITY AND GET TO KNOW US. WITHOUT PREJUDICE, I BELIEVE WE ARE A FRENDLY GROUP TO KNOW. THANK YOU.

## STATEMENT BY DR. ANNIE WAUNEKA

## TO HOUSE SELECT COMMITTEE ON AGING AND HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS OVERSIGHT HEARING

## ON BEHALF OF THE NAVAJO NATION

### I. THREE STATE STANDARDS:

The Navajo Nation, together with the Governors of the states of Utah, Arizona, and New Mexico have worked hard and long over the years to create an atmosphere of trust and cooperation in developing agreements and contracts by which services could be provided to Navajos residing within each state.

Recently, the Navajo Nation hosted the Governors of all three states in recognition of the accomplishments thus far and to further establish a mutual agreement between each state and the Navajo Nation for future planning, problem solving, and negotiations. The positive response, and willingness of each state, has demonstrated their continuing commitment of support to the Navajo Nation, a willingness to meet their responsibilities to all residents of their respective states.

This attitude of responsibility must be further demonstrated by the Federal Government, not only to individual states, but to the Navajo Nation through its Federal trust responsibility and treaty obligations.

Due to our unique service area, the Navajo Nation programs must deal with compliance issues that are not experienced by most service populations.

Various Federal, State, and Tribal funds are used to provide aging services and programs. Federal regulations often conflict in terms of eligibility which is then further compounded by the three individual state income and eligibility standards. Depending on where you reside with the Navajo Nation, you may or may not be eligible for the same service as another person living directly across the state line. This impacts most heavily on the elderly.

The Navajo Nation has stated in previous public hearings that this problem needs to be addressed. However, the purpose of mentioning this issue is to draw attention to the enormous problem encountered with the three state standards in addition to the federal requirements of each funding source.

To cite an example, if a client receives Supplemental Security Income, in all probability, they will be considered ineligible for services provided under 93-638, the Indian Self-Determination Act. However, if a client receives SSI they are eligible for supplemental state health care and other services. In addition, if a client receives SSI under ACTION, the Federal Volunteer Agency, no client income criteria is necessary.

Title VI of the Older Americans Act, Direct funding to Indian Tribes, provides nutrition, transportation, legal and other social support services to the elderly as does Title III of the same Act. The Act stipulates that a combination of Title III and Title VI funds is prohibited. The current level of Title VI funding is not sufficient to equal the level of Title III funds allocated to Indian Tribes. Therefore, many Tribes receive two sources of funds from the same Act to provide the same services, but which in no way can be combined. Also Title VI is directly from the Federal agency while Title III comes through the added Regional and State systems.

The conflicting requirements, criteria and standards with which elderly of the Navajo Nation must contend simply to receive needed services only serves to add to their high risk condition; and results in an unnecessary lack of response to a tremendous human need.

## SELF-DETERMINATION VS. FEDERAL REGULATIONS:

Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1977 is understood by the Navajo Nation, through the Navajo Tribal Council, as intended for Tribes to prioritize, develop, and administer programs and services.

In October of 1981, the Navajo Nation contracted the BIA Social Services through P.L. 93-638. It was felt that the Navajo Nation and the Navajo Area BIA would join in a unified effort to insure that Navajo people received the much needed services that were available within the intent of the Act and that adequate appropriations would be provided to meet the documented need. Instead, the Navajo Area BIA applied their expertise to enforce the "letter of the law" rather than utilize the regulations as a "tool" with which to implement the services. Their main focus was to monitor the Navajo Nation. Whereas, the regulations within the 25 CFR could have been the means to further meet the needs of the people, it became the 'club' with which to impose inflexible demands based on the narrow interpretation of the law. The Navajo Area held the Navajo Nation accountable in a manner that even they, the Bureau, had never been subjected to.

When the Navajo Nation took over BIA Social Services in October, 1981 hundreds of pending cases and applications remained unassessed. BIA'S justification was that the Tribe would be assuming the social services contract.

Of those elderly clients that were assessed by BIA, the majority remained unserved and funding projections turned in by the Navajo Area BIA remained grossly inaccurate since they were based on service levels and statistics which were not inclusive of numerous clients unassessed beyond 45 days, unassessed due to anticipation of the Navajo Tribe assuming the BIA Social Services operation, and unassessed due to conflicting procedures and requirements.

Certification of clients was resumed once the contract was transferred to the Navajo Nation, utilizing the procedure established previously under the BIA. Within a year of the tribal contract, under the scrutiny of the BIA, the Navajo Nation was instructed to apply state income standards in a manner which resulted in approximately 300 elderly clients being determined ineligible within a six month period. Many of the clients had been previously certified and/or recertified as eligible for services under 93-638 by the BIA for the past several years. The interpretation by this Federal Agency has turned the dream of self-determination into a nightmare for clients

## AGING POLICY

A National Indian Aging Policy was expected to be drafted by the Administration on Aging in 1982. Although public hearings and written testimony have been continually provided to expedite the development of a policy from the Navajo Tribe and other Tribes throughout the Nation, no policy has been forthcoming.

This delay in drafting and implementing a policy has resulted in numerous Indian Tribes and organizations being underfunded or not funded at all, although their elderly population has continually increased and the needs of the elderly have continued to magnify during the delay in developing a policy.

Although the Federal Government, through the Administration on Aging, has been responsible for the two year delay, the Navajo Tribe, through Navajo Tribal Chairman Peterson Zah, has identified three major tribal policy areas to be developed and implemented in the immediate future. These are:

(1) Provide adequate health, nutrition, transportation, and housing assistance for Senior Citizens, and

(2) Establish Advisory Committees to encourage the participation of our senior citizens in the Tribal government, and

(3) Involve Navajo Senior Citizens in the cultural education of our youth.

It is demonstrated through the development of these policy areas, as well as a yearly tribal appropriation of approxmiately 25 million for direct services, that the Navajo Tribe puts a very high priority on the well-being of the elderly members of the Tribe. In turn, we request that the Federal Government uphold their trust responsibility to the Indian people by putting a priority on our elderly tribal members as well, through immediately developing a National Indian Aging Policy with Tribes and Indian organizations, and subsequently requesting adequate appropriations from Congress to implement the policy throughout the Nation.

To assist in the accomplishment of this goal, the Navajo Nation will continue to call upon the Congressional leadership and Governors of the three states of New Mexico, Utah, and Arizona, to support and assist in the development of a National Indian Aging Policy cooperatively with all Tribes and Indian organizations.

The Navajo Nation wants a culturally conducive policy that will truly impact on the lives of our elderly, a policy designed from a tribal viewpoint rather than a federal viewpoint. That policy must prioritize the needs of the elderly over the concern to save the federal dollar. It is very important that this policy become a reality THIS YEAR, not next year, or two or three years from now.

The knowledge, wisdom, and identity we lose as Indian people with the passing of the traditional Navajo elderly is too precious and valuable to let us allow this delay to continue. As Indian Tribes and organizations we must make a comprehensive effort to see that our elderly are well-cared for and protected in the immediate future, not only for their total well-being, but for our cultural identity and survival as Indian nations in this country.

## OVERALL RECOMMENDATIONS

Based on the three areas of concern I have expressed: (1) three state standards, (2) Self-Determination vs Federal Regulations, and (3) the development of a National Indian Aging Policy, the overall recommendations of the Navajo Nation to this oversight hearing are as follows:

1. $50 million dollars be appropriated for Title VI of the Older Americans Act from Congress;
2. An Indian Desk be established at the Administration on Aging to be filled by a qualified Indian aging professional;
3. $30 million dollars be appropriated for Title V of the Older Americans Act through DIRECT FUNDING from Congress;

4. A comprehensive three year budget and proposal be approved by the BIA for Indian Aging Programs established under the Indian Self-Determination Act, and a subsequent request be made by BIA to Congress for adequate appropriations.

5. The Senate and House Select Committees on Aging request monthly update on the progress of an Indian Aging Policy from the Commissioner on Aging until such time the policy is developed, and

6. Per President Reagan's statement last January 1983, government to government relations between the Federal government and recognized Indian Tribes be stressed and prioritized in funding and policy development areas in relation to Aging programs and services.

The Congress of the United States has invested in the elderly to uplift their daily lives and for this we are appreciative. Thank you for this opportunity to make the concerns and recommendations of the Navajo Nation known through this hearing.

May 25, 1984

Tucson, Arizona

Select Committee on Aging
Committee on Interior and Insular Affairs
Joint Hearing on 'Long Term Care Public Policy Issues:
'Their Impact on Health and Social Services for Elderly Indians'

Good morning, Mr. Chairman and members of both committees. My name is Ray Olney. I am an enrolled member of the Yakima Tribe in the state of Washington. I am a member of the Yakima Tribal Council. Mel Sampson was scheduled as a witness at this oversight hearing but is unable to attend due to last minute changes. I am delegated to replace Mr. Sampson as witness representing the Yakima Tribe. Our Tribe is a federally recognized tribe established by treaty in 1855. On behalf of the Tribe, I would like to thank both Committees for the opportunity to present testimony on issues that impact our Indian Elders.

I would like to summarize our statement and entertain questions as much as possible after summarizing.

Because of the critical role that the older tribal members play in the day-to-day life of the Yakima Indian Nation we are extremely concerned with providing the best and most effective services to each and every one of them. Unfortunately, our goal of providing these critically needed services has been severely inhibited by a total lack of coordination on the part of various Federal agencies, unclear and cumbersome Federal regulations, and a severe shortage of funds.

In the fiscal year 1983 the Yakima Nation's Area Agency on Aging received its funding from four predominant sources, primarily Title VI, Title III of the Older Americans Act, State funds provided under a State statute and contributing, also, was the Tribe.

The Title III funds are utilized by an on-reservation elderly nutrition program. This program allows us to distribute hot meals to a limited number of elderly members who can not leave their homes for various medical reasons. It is also utilized to provide a centralized lunch program for older tribal members who come to have a hot meal. Because of the size of our reservation and the Federal regulations which require us to service all Indian and non-Indian citizens living within the boundary of the reservation -- I think a key factor is that we presently, on our reservation, have a ratio of three to one who are non-Indians who live on the reservation or within the exterior boundaries of the reservation.

Then under the Title III funding, it is also used to provide an equally critical service, that of outreach assistance. And because of the older people not being educated, they have extreme difficulty completing forms for such services as social security, food stamps and Medicare; and to make matters worse the closest service office on the reservation is an average of 20 to 25 miles for the elderly. So, consequently, the outreach program through our elderly program is a major factor in our elderlies participating in the other Federally-funded programs.

I feel it is important to take a moment to discuss the unique and ofter severe problems which many of our older people face, and this primarily is in the certification area for eligibility for services in the health or lack of health related areas that they are confronted with, and then the income level criteria that they are also confronted with.

Despite these proven facts, Federal regulations make no attempt to take them into consideration when allocating funds to Indian aging programs, and we feel that this is wrong.

And I think of major importance also is due to the budget cuts, a serious problem has been created in the health support area. First, the Yakima Indian Nation has been using the remainder of our State-funded dollars under the State Senior Citizens Service Act to purchase health appliances, such as glasses, dentures, hearing aids, etc., for those individuals who could not receive social assistance from Indian Health Service funds.

In the Portland area; Washington, Oregon and Idaho, that is the only area within Indian Health Service areas that does not have an Indian Health Service referral hospital. So, consequently, we function extensively on contract care funds for referral systems.

So we have literally been put in a situation where we have to prioritize who is going to receive the service. And when you come to hearing aids, glasses, and these types of incidentals, they are put on the bottom of medical priorities and this includes those who are senior citizens.

The Indian Health Service in the Portland Area does not provide special programs that target the Indian Elders. Older Indians are included in all health and social services that are provided for all other segments of the population.

On the issue of joint agreements or cooperative health projects between Federal Agencies: An agreement between the Health Services Administration (of which Indian Health Services is a part) and the Administration on Aging was entered into early in 1979, and covered the fiscal years of 1979, 1980 and 1981. One result of the agreement was the funding of the Yakima Home Health Care Program, one of three Indian programs funded nationwide. The agreement was conditional and dependent on the continuing availability of funds.

The Yakima Tribe provided Home Health services that demonstrated effectiveness in treating and caring for the frail and chronically impaired older Indian people. After proof had been delivered that such activities are critical to the well-being of our elders, and after creating a dependency for such treatment and care, project support was discontinued by all Federal agencies with no future year considerations.

That has been our experience with Inter-Agency agreements on health services for Indian elders.

The Bureau of Indian Affairs at the Yakima Agency acknowledges it's custodial, domicilial, and general long term care responsibilities to Indian elders, but offers no special set-aside or programs except HIP grants or separate home programs.

I will not go into the need for extended care facilities for the Indian elders on the Yakima Reservation, since I expect that such testimony will be presented repeatedly here today. Let's suffice ~~it~~ to say that the need exists the same on my Reservation as it does anywhere else in Indian Country.

In conclusion, I would like to assure all concerned that the Yakima Indian Nation is willing at any time to work with any group or agency in the effort to enhance the quality of life for Indian Elders while preserving their pride and rich culture.

Thank you again Mr. Chairman for the opportunity to testify today.

# STATEMENT OF SENATOR DENNIS DECONCINI
# AT THE HEARING
# BEFORE THE HOUSE COMMITTEES ON AGING
# AND THE INTERIOR & INSULAR AFFAIRS
# ON
# MAY 25, 1984
# TUCSON, ARIZONA
# HEALTH CARE FOR THE INDIAN ELDERLY

[illegible] 24 [illegible] 9 05

I regret that prior commitments prevent me from joining the Chairmen and members of this distinguished panel here today. However, I do thank both the Aging and the Interior and Insular Affairs Committee Chairmen for coming to Arizona to hear about the health care needs of Indian elderly from the tribes and the elderly themselves. The power and prestige of your committees will be critical to any congressional action necessary to address the numerous concerns presented today.

Your findings will certainly be invaluable to efforts in the Senate where I, with a number of my colleagues, am pressing for

THE TIMELY DEVELOPMENT OF A LONG NEEDED NATIONAL POLICY ON INDIAN AGING. IN FACT, I HAVE ASKED THAT THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS HOLD JOINT HEARINGS WITH THE SENATE SPECIAL COMMITTEE ON AGING AND THE AGING SUBCOMMITTEE OF THE LABOR AND HUMAN RESOURCES COMMITTEE ON INDIAN AGING POLICY ISSUES IN THE VERY NEAR FUTURE.

MY EXPERIENCE IN WORKING ON INDIAN AGING MATTERS HAS TAUGHT ME THAT NATIVE AMERICAN ELDERLY KNOW WHAT THEIR POLICY AND SERVICE NEEDS ARE. SO I AM SURE THAT YOU WILL NOT LEAVE TUCSON WITHOUT RECEIVING THE FULL BENEFIT OF THEIR VIEWS AND RECOMMENDATIONS. THEIRS IS A PERSPECTIVE WHICH SHOULD GUIDE ALL WHO MAKE THE POLICY AND PROVIDE THE SERVICES ON WHICH THE ELDERLY DEPEND TO ENJOY A BETTER QUALITY OF LIFE.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS MY SUPPORT AND APPRECIATION FOR YOUR EFFORTS ON BEHALF OF THE INDIAN ELDERLY.

## STATEMENT TO THE HOUSE SELECT COMMITTEE ON AGING

### SENATOR EDWARD R. ROYBAL, CHAIRMAN

I am here today to present information on the need for Long Term Care facilities for our Elderly American Indian population. Statistics show that in United States the life span has increased for the Elderly. This is true for the American Indian.
In the past decade our life span has increased to 71 Years.*
Infant Mortality is lower, birth rates increased which tells us Long Term Care demands will increase over the next several decades.

There are many factors to consider in determining health needs of our Indian Elderly, the socio-economic conditions on the reservation contribute to a greater need for special services to the elderly in the area of long term care.
We have a population of 300 over 60 years of age. Many of them reaching a point of no longer being able to live alone. The fact that we do have abused elders, who need our consideration, protection and care.

The Omaha Tribe owns a 25-bed Long Term Care facility, built under an EDA Grant. It is operated under a P.L. 93-638 contract with Indian Health Service. In 1977 a congressional add-on provided funds for the staffing and operation of this facility which included the Nursing Home and an Ambulatory Care Unit for an Out-patient Clinic for the Tribe.

* - U.S. all races M & F - 77.5 years
American Indian M & F - 71.0 years
U.S. all races M - 73.7 American Indian M - 67.1
F - 77.5 F - 75.1

Indian Health Service took the stand that they were not in the Nursing Home business, but since the funds and facility were in place, they would have to be. This has been their stance. There is no consideration to our facility as a health delivery resource, important in the total health of Indian people. Nor has technical assistance been available or additional funds since 1977.

To offset this gap we do utilize Third Party funds from Medicaid. Our statistics of utilization have no place in the reporting system of Indian Health Service, consequently our occupancy rate is not considered, with number of in-patient days of care provided in a true cost analysis. There are positive factors to our operation, wherein the local Indian Health Service hospital and the Aberdeen Area Office do work in harmony with our facility within the realm of available resources.

As a care unit we provide all of the required services for rehabilitation. We are now forced to provide Skilled Care and are waiting for our State Survey and Certification. This will enable us to provide a more acceptable level of care, as our Elderly (and their families) do not like to have patients transferred to another facility.

An unmet need exists in the area of Long Term Care for Indian Elderly both in the Skilled and Intermediate Care levels. This is evidenced by the small number (8) of existing Long Term Care facilities providing care to Indian residents. We consistently receive requests for admission, from urban Centers and other States, which we can not fill.

The Tribally owned and operated facilities are operated in a manner pleasing and acceptable to our Elderly. Their cultural needs can be met in unique ways as well as emotional and physical.
Many times residents are transferred to our facility from off reservation facilities, so sedated they are more dead then alive. It takes us weeks to bring them out of this, and adjust to less medical restraints.

We are in position to expand our services.
The Tribe owns the facility and apparantly no resources exist to allow expansion. Priority for facility construction does not exist in construction funds of I.H.S.
If our health care system is to become solvent we need to be able to provide services to more residents at increased levels of care.

If Tribes are to operate Long Term Care facilities, and we should, there must be adequate support in obtaining facility resources. There must be funds available to expand facilities to be able to generate income with the potential to become self sufficient through generated income.

Long Term Care is a health need largely unfulfilled by the Indian Health Service.
We should note the trends of health care today. That Health Care delivery of the future will be in the Long Term Care, Intermediate, Skilled and Habilitive, and the Ambulatory settings.

RESPECTFULLY SUBMITTED: Pauline Tyndall

Pauline Tyndall, Executive Director
Carl T. Curtis Health Education Center
OMAHA TRIBE OF NEBRASKA

Honorable Congressman and members of the committee. My name is Howard McKinley Sr., of the Navajo Nation. This is my consumer testimony, and these are my prioritized consumer concerns for long term care:

1. Adequate, cultutally-conducive Housing; and
2. Dependable Transportation.

In order to secure federal funding to meet the basic needs of the Indian elderly, it is mandatory and urgent that we unite all our efforts including the Tribe, State and Federal Governments. We need immediate attention to clarify conflicting federal regulations and develop an Indian Aging Policy. In addition, a very clear definition of self-determination from a tribal viewpoint must be enforced.

A happy home is the focal point for many existing services and programs, such as transportation, nutrition, health and social services to allow the elderly the independence to stay within their own environment. Simply stated, as expressed in the old song, "Be it ever so humble, there is no place like home sweet home."

On behalf of the Navajo Nation, I present these important concerns and make known for the record that the Navajo Aging Services will present additional written testimony within 20 days of this hearing. Thank You.

THE NAVAJO NATION
WINDOW ROCK, NAVAJO NATION (ARIZONA) 86515

PETERSON ZAH
CHAIRMAN, NAVAJO TRIBAL COUNCIL

EDWARD T. BEGAY
VICE CHAIRMAN, NAVAJO TRIBAL COUNCIL

August 14, 1984

Mr. Jorge J. Lambrinos
Staff Director
Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20006

Dear Mr. Lambrinos:

Please find attached recommendations from the Navajo Nation Council on Aging, Inc. compiled as a result of the public hearing in Tucson, Arizona on May 25, 1984. These recommendations were gathered through a Navajo Nation public hearing held on July 19, 1984 at Greasewood, Arizona called by the Navajo Nation Council on Aging, Inc.

On behalf of the 16,000 Navajo elderly, the Navajo Nation Council on Aging, Inc. submits these recommendations for the record to the U.S. House of Representatives Select Committee on Aging.

The Navajo Nation Council on Aging, Inc. requests that immediate follow-up be made on these recommendations through the House Select Committee on Aging by contacting in writing each Federal Agency responsible for developing these recommendations.

The Navajo Nation Council on Aging, Inc. furter requests the House Select Committee on Aging to specifically hold the Indian Health Service, the Bureau of Indian Affairs, and the Aministration of Aging to their equal and concurrent responsibility to he Indian elderly by bringing these recommendations to their attenion, and seeing that they are followed-up on by these Federal Agencies.

Please contact the Navajo Aging Services Depatment at (602) 871-6790 if you need further information or assistance

Kenneth Cody
Kenneth Cody, Chairman, NNCOA

Howard McKinley
Howard McKinley, Vice-Chairman, NNCOA

Jane Grey
Jane Grey, Secretary, NNCOA

## A RESOLUTION OF THE
## NAVAJO NATION COUNCIL ON AGING, INC.

**Requesting support of needs expressed by the elderly through a Public Hearing on July 19, 1984 called by the Navajo Nation Council on Aging, Inc.**

WHEREAS:

The attached recommendations were the result of a public hearing called by the Navajo Nation Council on Aging, Inc. at Gresewood, Arizona on July 19, 1984;

This public hearing was called for purposes of providing the elderly an opportunity to express their needs in accordance with the intent of the Older American's Act of 1965, and revised Older American's Act of 1978;

This public hearing is also the Navajo Nation Council on Aging's additional input and testimony for the record to the U.S. House of Representatives Select Committee on Aging Public Hearing held in Tucson, Arizona on May 25, 1984.

THEREFORE BE IT RESOLVED:

The Navajo Nation Council on Aging, Inc. requests the Navajo Tribal Council accept and support these recommendations;

The Navajo Nation Council on Aging, Inc. requests all Congressional representatives in the states of New Mexico, Utah, and Arizona accept and support these recommendations;

The Navajo Nation Council on Aging, Inc. requests the U.S. House of Representatives Select Committee on Aging to include this testimony in the record of the public hearing entitled, " Long Term Care: Public Policy Issues", held in Tucson, Arizona on May 25, 1984.

### CERTIFICATION

We hereby certify that the foregoing resolution was duly considered at a duly called meeting at Window Rock, Arizona at which a quorum was present and that same was passed by a vote of 9 in favor and 0 opposed this 14th day of August, 1984.

MOTION: Wayne Freeland

SECOND: Louva Dahozy

Kenneth Cody
Kenneth Cody, Chairman, NNCOA

Howard McKinley
Howard McKinley, Vice-Chairman,NNCOA

Jane Grey
Jane Grey, Secretary, NNCOA

### RECOMMENDATIONS
### OF
### PUBLIC HEARING

The following recommendations are hereby adopted by the participants in this Public Hearing on Elderly Needs:

1. That 100% of tribal and federal funding be maintained for all Senior Citizen Services on the Navajo Nation in FY 1985' including the Foster Grandparent, Senior Companion, Senior Centers, and Group Home Programs,
2. That a Special Committee on Aging be established in the Navajo Tribal Council to respond to the documented needs of the elderly by October 1, 1985.,
3. That the Indian-Self Determination and Education Assistance Act be provided adequate funding by the Bureau of Indian Affairs to meet the documented needs of the elderly in FY 1985 through the regular budget process, budget savings, and special appropriation requests to the Congress of the United States.,
4. That the Indian Health Service provide FY 1984 year end funds and permanent funds thereafter for dentures, hearing aides, and eyeglasses for the elderly.,
5. That the U.S. Select Committee on Aging of the House of Representatives and Senate assist the Navajo Tribe and its elderly tribal members by requesting Federal Agencies to meet their equal and concurrent trust responsibility to the elderly, including the BIA, IHS, and Administration on Aging.,
6. That the Navajo Tribe develop a Navajo Tribal Aging Policy and that elderly tribal members be provided an opportunity for input in the development of the policy.,
7. That the Navajo Tribe and all Federal Agencies support the immediate development of a National Indian Aging Policy by the end of this calendar year.,
8. That a Navajo Tribal Code be established to protect the elderly against various forms of abuse, neglect, and exploitation in FY 1985.,
9. That various tribal offices develop a funding request to Arizona, New Mexico, and Utah legislatures to expand and develop senior services on the Navajo Nation.,
10. That various tribal offices and officials responsible develop a funding request to private foundation to expand and develop senior services to the Navajo Nation.,
11. That elderly be given the opportunity to contribute their knowledge in all educational settings on the Navajo Nation.,
12. That an annual Public Hearing be held for the elderly of the Navajo Nation in July of each year.,
13. That the elderly in the Former Joint Use Area receive priority in program planning and funding allocations by federal and tribal sources immediately;
14. That a minimum of 10% of the annual allocation of Tribal Revenue Sharing funds be earmarked for the elderly, age 60 years and older, for direct services;
15. That a minimum of 8% of the annual interest earnings of the Navajo Tribe Land Settlement be earmarked for the elderly, age 60 years and older, for direct services.

07 June 1984

Congressman Edward R. Roybal
Chairman Select Committee on Aging
U. S. House of Representatives
Room 712, HOB Annex # 1
Washington, D. C. 20515

Honorable Chairman Roybal,

Enclosed please find a listing of my testimony as presented before your committee on May 25, 1984 in Tucson, Arizona. Also enclosed are support documents which should provide additional information in considering the statements made or figures mentioned on same of the proposed recommendations.

May I command you for the opportunity and in the manner in which the hearing was conducted. Together, I know we can all bring about improved services to all older Indians and all elders in general. My exposure in presenting testimony was an experience which I intend to utilize to my advantage in bringing about quality services to our New Mexico Older Indian citizens.

Thank you again, and if you need additional information regarding contents of this submission, please do not hesitate to contact me at (505)465-2214, Ext. 34.

Respectfully submitted,

Martin Bird, Chairman
New Mexico Title VI Indian Coalition

ENCLOSURE:

cc/ New Mexico State Agency on Aging
    Office files

Summarized recap of recommendations to U.S. Senate Select committee on Aging. Presented in Tucson, Arizona, May 25, 1984. Recommendations not listed in priority:

1. Development of a National Indian Aging Policy, initiated and prepared by the United States Native Indian Americans.

2. Previous Title VI recommendations reviewed, approved and implemented by fiscal year 1986 (Oct. 1, 1985).

3. Clarification of roles by Administration on Aging (Health and Human Services, HHS-AOA), United States Bureau of Indian Affairs (BIA), Indian Health Services Public Health Services (IHS-DHS), United States Veterans Adminstration (VA), Social Security System (including Supplemental Security Income - SSI), etc.

4. Request that you as representatives of your respective areas, along with President Reagan's Administration, and all future administrations, for a change, honor and fulfill the responsibilities of the government and the long list of broken treaties.

5. In-Home Health care is our priority before we consider a Nursing Home of any kind, on or off the reservation-firmly support all preventive services.

6. Establishment of a Indian Elderly Welfare Act.

TESTIMONY AS PRESENTED BY:
MARTIN BIRD, CHAIRMAN
N. M. INDIAN TITLE VI COALITION

THE NEW MEXICO INDIAN COUNCIL ON AGING (ESTABLISHED JUNE 1981) IN CONJUNCTION WITH THE NEW MEXICO INDIAN TITLE VI COALITION (ESTABLISHED OCTOBER 1982) ARE TWO BODIES OF CONCERNED INDIAN ORGANIZATIONS IN THE STATE OF NEW MEXICO. SINCE DIRECT FEDERAL GRANTS WERE AWARDED TO MAJORITY OF THE INDIAN TRIBES IN THE STATE, WE SAW THE NEED TO CONSOLIDATE AND ADDRESS ISSUES AND CONCERNS IN A UNIFIED APPROACH.

I AM PROUD TO ANNOUNCE THE INDIAN TRIBES IN THIS STATE HAVE BECOME AN IMPORTANT ARTERY WITHIN THE STATE AGING DEPARTMENT. NOT ONLY HAS RECOGNITION BEEN ACCEPTED AT ALL LEVELS OF STATE GOVERNMENT, BUT WE HAVE ALSO PROVIDED ESSENTIAL INFORMATION AND ASSISTANCE IN DEVELOPING A CONCISE AGING PLAN FOR THE STATE.

AS MY INTRODUCTION INDICATED IN TUCSON, ARIZONA ON MAY 25, 1984 BEFORE YOUR COMMITTEE, MY TESTIMONY DOES NOT ONLY REFLECT ON THE NEEDS OF ANY ONE INDIVIDUAL TRIBE, BUT AS AN OVERALL INDIAN AGING NEEDS IN THE STATE. I ALSO WISH TO EXPRESS THE LIST OF CONCERNS PROVIDED TO YOUR COMMITTEE ARE NOT NECESSARILY LISTED IN PRIORITY. FURTHERMORE, I HAVE MADE AVAILABLE FOR YOUR REVIEW AND RECORDS 1.) COPIES OF THE PROPOSED LONG RANGE PLANS FOR SANTO DOMINGO PUEBLO TRIBES ELDERLY NURSING CENTER (PROJECTED COSTS OF CONSTRUCTION, ETC. ARE OUTDATED); 2.) COPIES OF THE AGENDA, TESTIMONY BY TRIBES OR ORGANIZATIONS, SUMMARY RECAP OF THE MARCH 16, 84 NEW MEXICO INDIAN CONFERENCE ON AGING HELD IN SANTA FE; AND 3.) COPIES OF THE NATIONAL TITLE VI GRANTEES RECOMMENDATIONS AS ESTABLISHED IN ALBUQUERQUE IN MAY 1982.

THE DEVELOPMENT AND IMPLEMENTATION OF A "NATIONAL INDIAN AGING POLICY" IS A VERY IMPORTANT PART IN THE FUTURE GROWTH OF THE NATIONAL INDIAN AGING PROGRAMS. IF HAS BEEN FOUR (4) YEARS SINCE INCEPTION OF THE TITLE VI INDIAN AGING ACT - AND THE TRIBES RECEIVING FUNDING UNDER THIS ACT ARE STILL WITHOUT A CONSISTENT POLICY CREATING INCONSISTANCIES IN PROCEDURES, REPORTING, SERVICE DELIVERY, ETC. ALTHOUGH AN EVALUATION WAS CONDUCTED ON THE TITLE VI PROGRAMS IN 1982 AND 83, NOT MUCH WAS FOCUSED ON THE LACK OF A CONSISTENT "NATIONAL INDIAN AGING POLICY". I BELIVE THE INDIAN GRANTEES (EIGHTY THREE - 83 TRIBES) FORTUNATE TO RECEIVE FUNDING UNDER THIS ACT, WITH THE UNDERSTANDING TWENTY SEVEN (27) ADDITIONAL TRIBES WILL BE RECEIVING GRANTS IN FISCAL YEAR 1985 (OCTOBER 1, 84). WITH THE ADDITIONAL TRIBES TOTALLING ONE HUNDRED AND TEN (110) TRIBES I AM SURE THEY TOO WILL SHARE THE SAME FEELINGS AND CONCERNS AS WE DO. FURTHERMORE, AS I STATED DURING MY PRESENTATION, I WOULD REQUEST AND RECOMMEND THE INDIAN TRIBES BEGAN DEVELOPMENTS OF THE POLICY TO BE COORDINATED WITH THE BUREAU OF INDIAN AFFAIRS, INDIAN HEALTH SERVICES, VETERANS ADMINISTRATION, IN CONJUNCTION WITH THE INTERIOR DEPARTMENT AND ALL INTERESTED INDIANS OR ORGANIZATIONS TO BE SUBMITTED FOR STUDY, REVIEW, COMMENTS AND COORDINATION WITH THE ADMINISTRATION ON AGING AND ALL APPROPRIATE AGENCIES OR OFFICES RELATED TO THE INDIAN AGING ISSUES. TOO MANY TIMES TRIBES ARE GIVEN STATUTORY, REGULATIONS AND LAWS ESTABLISHED BY FEDERAL AGENCIES IN WASHINGTON, AND ARE FOUND NOT TO THE BEST NATURE OF IMPLEMENTATION BY THE TRIBES TO ACHIEVE MAXIMUM SERVICES AND RESULTS BENEFITTING THE INDIAN TRIBES. MY RECOMMENDATION IS THAT A JOINT EFFORT BE EMPLOYED TO SATISFY ALL CONCERNED. THE NEW MEXICO INDIAN AGING ORGANIZATIONS ARE STANDING READY TO ASSIST YOU WITH THIS EFFORT.

THE RECOMMENDATIONS SUBMITTED TO ADMINISTRATION ON AGING AND VARIOUSNEW MEXICO DELEGATION TO WASHINGTON, CLEARLY OUTLINES THE MAJOR AREAS OF CONCERN AND IMPROVEMENTS FOR A BETTER FUTURE FOR ALL INDIAN ELDERLY CITIZENS NATIONALLY. IT ADDRESSES THE NEED FOR ESTABLISHMENT OF AN INDIAN DESK WITHIN THE ADMINISTRATION ON AGING, INCREASED FUNDING ALLOCATION AS INDICATED, CONSORTIUM OF TRAINING, EMPLOYMENT, ENERGY ASSISTANCE, WEATHERIZATION AND OTHER PERTINENT SERVICES PROVIDED TO OLDER INDIANS TO SECURE THEIR WELFARE AND WELLBEING. OTHER IMPORTANT CONTENTS WHICH REINFORCE SELF SUFFICIENCY, SOVEREIGNTY, HONOR AND DIGNITY AMONG OUR OLDER INDIAN CITIZENS.

THE NEXT ISSUES AS EXPRESSED FREQUENTLY BY MANY OF THE OTHER INTERESTED INDIANS PRESENT AT THE TUCSON CONFERENCE IS THE CLARIFICATION OF ROLES PLAYED BY NOT ONLY THE ADMINISTRATION ON AGING (AoA-HHS), BUREAU OF INDIAN AFFAIRS (BIA), INDIAN HEALTH SERVICE-PUBLIC HEALTH SERVICES (IHS-DHHS), VETERANS ADMINISTRATION (VA), SOCIAL SECURITY ADMINISTRATION (SSA), SUPPLEMENTAL SECURITY INCOME (SSI) AND MANY OTHER SERVICES OR ENTITLEMENTS DUE NOT ONLY OUR INDIAN ELDERLY BUT TO ALL OLDER UNITED STATES CITIZENS. TOO MANY TIMES WHEN PROGRAMS SEEK FOR HELP FROM THE ABOVE SOURCES ON BEHALF OF THEIR OLDER INDIAN CLIENTS - WE FACE UNNECESSARY DELAYS, RED TAPE, OBSTACLES AND PASSING OF THE BUCK, WITH WHO IS TO BE RESPONSIBLE WITH CERTAIN SERVICES. AS A RESULT OUR ELDERLY CLIENTS BECOME IRRITATED, ANGERED, ETC. - LETS KEEP IN MIND, MANY OF THESE CLIENTS ARE FRAIL, HANDICAPPED, INDIGENT OR WHATEVER IT IS THAT OLDER PEOPLE EXPERIENCE AS THEY GROW OLD. ALSO MANY OF OUR OLDER INDIAN MEN FOUGHT FOR THE FREEDOM OF OUR COUNTRY, SOME DURING WORLD WAR I AND II, KOREAN AND GOD KNOWS WHAT OTHER WARS TRIBES HAD TO FIGHT INORDER TO SUSTAIN THEIR FREEDOM AND THEIR LAND. NOW

THAT THEY ARE OLDER, HEALTH AND MEDICAL SERVICES PROVIDED IS VERY LIMITED, PROCESSING OF SERVICES OR DETERMINATION OF IS VERY TIME CONSUMING AND SO ON. THESE PEOPLE HAVE GIVEN THEIR TIME SO WE DOULD ALL ENJOY LIFES PLEASURES WE SEE TODAY - AND WE ARE UNWILLING TO PROVIDE THEM WITH ADEQUATE SERVICES.

AS RESPECTED NATIONAL LEADERS OF THIS GREAT NATION OF OURS, I AM APPEALING TO YOU TO TAKE A SECOND OR THIRD LOOK AND GIVE IT SOME CONSIDERATION OF THE RESPONSIBILITIES EACH AND EVERYONE OF YOUHAVE IN REPRESENTING THE PEOPLE OF THIS NATION. I APPEAL ESPECIALLY TO YOU, OF THE UNITED STATES GOVERNMENTS COMMITTMENT AND TRUST TREATY RESPONSIBILITIES TO ALL INDIAN CITIZENS. HISTORY INDICATES A LONG AND FREQUENT VIOLATIONS OF THESE TREATIES. WE ARE NOT ASKING FOR A HAND OUT - BUT TO HONOR AND CARRYOUT THE PROMISES MADE CENTURIES AGO TO ALL FEDERALLY RECOGNIZED INDIAN TRIBES.

THE IN-HOME HEALTH AND MEDICAL CARE SERVICES WILL BE OUR PRIORITY BEFORE WE CONSIDER A NURSING HOME OF ANY SIZE, SHAPE OR FORM - ON OR OFF THE RESERVATION. RETENTION OF THE OLDER INDIANS IN THEIR OWN HOMES AND RESERVATIONS IS OUR PRIMARY CONCERN. MANY OF OUR ELDERLY CITIZENS ARE CONSERVATIVE AND TRADITIONAL LEADERS OF OUR COMMUNITIES, MANY HOLD HONORABLE AND PRESTIGIOUS POSITIONS WITHIN THEIR TRIBES AND NEED TO BE CLOSE TO THOSE IN NEED OF THEIR ASSISTANCE AND SERVICES. WE FIRMLY SUPPORT ALL PREVENTIVE MEDICAL AND HEALTH MEASURES TO PROLONG THEIR ACTIVE ROLE AND MEMBERSHIP WITH THEIR TRIBES BY PROVIDING QUALITY HEALTH AND MEDICAL SERVICES THROUGH THE LOCAL HEALTH FACILITIES, COMMUNITY HEALTH NURSING PROGRAMS AND OTHER MEASURES FEASIBLE IN SECURING THEIR STAY IN THEIR OWN HOMES. WE ALL REALIZE WE CANNOT PUT A CAP ON THE CONCEPT OF GETTING OLD - BUT WE CAN SURELY MAKE THEIR FINAL DAYS A PLEASANT AND HONORABLE ENDING. WE HAVE WITNESSED SO MANY INDIAN ELDERS WHO

ARE COMMITTED TO OFF RESERVATION NURSING CENTERS - TO BE VERY UNPLEASANT, UNHAPPY, HOPELESSNESS AND THE WILL TO LIVE SUBSIDES - RESULTING IN RAPID DETERIORATION OF HEALTH, BODY AND SOUL. THESE OLDER INDIANS NEED TO WITH FAMILIAR SETTINGS, LANGUAGE, TRADITIONS AND THE VERY ATMOSPHERE HAS TO BE INDIAN. AS I STATED, THEIR NEED TO BE WITH LOVED ONES, FAMILIES, FRIENDS, CULTURE, TRADITIONAL PRACTISES AND EVERYTHING AROUND THEM IS VERY IMPORTANT. I DO NOT BELIEVE IN DEPRIVING THEM OF THESE RIGHTS JUST BECAUSE THEY ARE OLD. AGAIN I APPEAL TO YOU THAT EFFORTS BE UNDERTAKEN TO FULFILL THE ABOVE CONERNS AND RECOMMENDATIONS.

THE LAST BUT SURELY NOT THE LEAST, IS THE ESTABLISHMENT OF AN "INDIAN ADULT AND ELDERLY WELFARE ACT". WE HAVE VARIOUS ACTS AND LAWS WHICH PROTECT THE RIGHT OF THE INFANT, CHILDREN, ETC. BUT HAVE AGAIN FAILED TO PROVIDE PROTECTION TO OUR OLDER INDIAN CITIZENS. IN MANY CASES WHERE ABUSE, NEGLECT, ABANDONMENT OR THE LIKE IS SIGHTED OR REPORTED, NOT MUCH CAN BE ACCOMPLISHED DUE TO LACK OF ADEQUATE LANGUAGE OR STATUTES, THEREFORE LIMITING PROTECTION FOR THE OLD. IN SITUATIONS WHERE NON-INDIANS ARE INVOLVED, THESE PROCEDURES ARE MADE TWICE AS HARD BECAUSE OF LIMITATIONS OR JURISDICTIONAL RESTRICTIONS.

THESE ARE BUT A FEW OF OUR CONCERNS WE WICH YOU TO CONSIDER IN IMPROVING SERVICES TO OUR INDIAN ELDERS. ONCE AGAIN THE NEW MEXICO DELEGATION STAND READY TO ASSIST YOU IN YOUR EFFORTS. THANK YOU ONCE AGAIN FOR THE OPPORTUNITY TO PRESENT OUR CONCERNS AND HOPE THE RECOMMENDATIONS COMPILED WILL BENEFIT OUR INDIAN ELDERS.

# SECOND NEW MEXICO INDIAN CONFERENCE
# ON - AGING
## FRIDAY - MARCH 16, 1984

THIS ONE DAY CONFERENCE SPONSORED JOINTLY BY THE NEW MEXICO INDIAN COUNCIL ON AGING AND NEW MEXICO TITLE VI COALITION HELD AT COLLEGE OF SANTA FE GREER GARSON THEATHER, SANTA FE, NEW MEXICO WAS ATTENDED BY APPROXIMATELY 325 OLDER INDIANS AND INTERESTED PERSONS.

REPRESENTATION BY MOST OF THE INDIAN TRIBES OR RESERVATION WAS THERE WITH THE EXCEPTION OF THE NAVAJO NATION AND MESCALERO APACHE (ALL INDIAN AGING PROGRAMS AND OFFICES AND TRIBAL ADMINISTRATIONS NOTIFIED).

THE MORNING SESSION WAS PRIMARILY A GENERAL SESSION WITH GUEST SPEAKERS MAKING REPORTS OR PRESENTATIONS OF NEW MEXICO'S AGING PROGRAMS, ETC. OUR FIRST SPEAKER WAS DR. JOSEPH GOLDBERG, DIRECTOR OF NEW MEXICO HUMAN SERVICES DEPARTMENT. HE WAS SCHEDULED TO SPEAK AND ADDRESS THE SERVICES HIS DEPARTMENT WAS PROVIDING AND WHAT THE TRIBES CAN ANTICIPATE IN THE FUTURE. HOWEVER, DR. GOLDBERG WAS UNABLE TO ATTEND DUE TO THE LEGISLATIVE SESSIONS AND BECAUSE OF THE RECENT ADMINISTRATIVE CHANGES BETWEEN THE DEPARTMENTS MADE MY GOVERNOR ANAYA.

MR. GEORGE ELLIS, DIRECTOR NEW MEXICO STATE AGENCY ON AGING MADE A REPORT ON PAST EFFORTS OF THE INDIAN COUNCIL AND COALITION AND THEIR ACCOMPLISHMENTS. HE REPORTED THAT TODAY MORE THAN EVER, BOTH THE STATE AND INDIAN PROGRAMS WERE WORKING CLOSELY WITH EACH OTHERS. ONE INDICATION IS THE RECENT APPOINTMENT OF THREE (3) INDIAN INDIVIDUALS TO THE AAA BOARD OF DIRECTORS AND

ADVISORY COUNCIL AND THE PENDING STATE AGING ADVISORY COUNCIL WHICH CONSISTS OF A NINE (9) MEMBERS STILL TO BE APPOINTED BY GOVERNOR ANAYAS OFFICE. THE INDIAN ORGANIZATION STILL HAS (3) THREE INDIAN INDIVIDUALS TO THAT APPOINTMENT WITH THE ANTICIPATION OF BRINGING ABOUT STILL IMPROVED SERVICES TO THE STATES OLDER INDIANS.

MR. SEFERINO TENORIO, OWNER AND EXECUTIVE DIRECTOR - NATIVE AMERICAN MANAGEMENT AND EDUCATION SERVICES ADDRESSED THE ROLE OUR OLDER INDIANS PLAY BOTH TRADITIONALLY AND WITHIN THE NON-INDIAN SOCIETY. HE MADE REFERENCE TO THE VALUES OF THE MEANING "INDIAN" AND WHAT WE SHOULD BE FIGHTING FOR IN PRESERVING OUR HERITAGE AND CULTURE, TO ENCOURAGE OURSELVES TO IMPROVE OURSELVES, TO CHALLENGE THE GOVERNMENT IN SERVICES OUR TRIBES ARE RECEIVING AND CONTINUE SEEKING IMPROVED SERVICES THROUGH FEDERAL, REGIONAL, STATE AND OTHER AGENCIES. THE IMPORTANCE OF INCREASING THE VALUES OF ECONOMIC AND STRUCTURAL DEVELOPMENTS WAS STILL ANOTHER PRIORITY BY MANY INDIANS IN ALL AREAS WAS ANOTHER FACTOR STATED. THE NEED TO COORDINATE, HAVE A BETTER UNDERSTANDING AND SUPPORT BY THE LOCAL GOVERNMENTS WAS THE KEY BEHIND HAVING A SUCCESSFUL SERVICES AND PROGRAMS.

MR. RAMUS SUINA, DEPUTY DIRECTOR OF THE OFFICE OF INDIAN AFFAIRS WAS OUR NEXT SPEAKER, HE IS A NATIVE COCHITIAN. HE HAS BEEN VERY VISIBLE AND HAS PROVIDED MANY TECHNICAL AND LONG STRENEOUS HOURS IN ASSISTING THE INDIAN ORGANIZATIONS IN ACCOMPLISHING THEIR GOALS WITHIN THE STATE GOVERNMENT. HIS ENTHUSIASM AND ENERGETIC INVOLVEMENT HAS OPENED MANY DOORS WHEREBY OUR GROUP HAS BEEN SUCCESSFUL IN DISCUSSING ISSUES AND WORKING OUT CONSTRUCTIVE PLANS TO BENEFIT OUR OLDER INDIANS.

THE LAST SPEAKER WE HAD WAS MR.ERNESTO RAMOS, DIRECTOR OF THE STATE ACTION OFFICE. THIS OFFICE IS RESPONSIBLE FOR A PART OF THE STATES SENIOR EMPLOYMENT SERVICES OF WHICH THE ALL INDIAN PUEBLO COUNCIL, INC. HAS SUBCONTRACTED FOR THE SENIOR COMPANION PARTICIPANTS. HE ALSO REPORTED THAT HIS OFFICE AND STAFF HAD WORKED CLOSELY WITH THE INDIAN COMMUNITIES IN EFFORTS OF BRINGING IN MORE EMPLOYMENT FOR THE INDIANS THROUGH STATE AND OTHER AGENCIES. HE ALSO ENCOURAGED INVOLVMENT, WORKING IN A UNIFIED APPROACH AND TO BE MORE ACTIVE IN LOBBYING AND VOTING ACTIVITIES INORDER TO HAVE AN INSIDE WITHIN THE STATE AND FEDERAL GOVERNMENTS.

TO RECAP THE MORNING SESSION, IT DEVELOPED VERY WELL ALTHOUGH WE WERE RUNNING SLIGHTLY BEHIND SCHEDULE. IT COVERED THE TRADITIONAL ASPECTS AS WELL AS PROGRAMATIC ISSUES. UNFORTUANATELY DUE TO EXTENDED PRESENTATIONS BY SOME OF THE SPEAKERS WE WERE UNABLE TO PROVIDE TIME FOR QUESTIONS AND ANSWERS FROM THE AUDIANCE.

THE AFTERNOON SESSIONS STARTED SLIGHTLY BEHIND SCHEDULE WITH INDIAN GROUPS PERFORMING AND OTHER INDIAN DANCES WHICH INVOLVED THE AUDIANCE PARTICIPATION. IMMEDIATELY FOLLOWING THE DANCES, THE GROUP BROKE UP INTO INDIVIDUAL TRIBES TO CONSIDER THEIR NEEDS, RECOMMENDATIONS, ETC. AND TO SELECT A SPOKESPERSON TO PRESENT FOR THEIR RESPECTIVE VILLAGES. THE OTHER CONSIDERATION WAS TO NOMINATE TWO (2) INDIVIDUALS FOR THE VACANCIES WITHIN THE NATIONAL INDIAN COUNCIL ON AGING BOARD OF DIRECTORS. PLEASE REVIEW THE COMMENTS OR RECOMMENDATIONS BY EACH TRIBE PER ATTACHED LISTING. THE RESULTS OF THE NEEDS AND RECOMMENDATIONS WERE THAT MOST OF THE TRIBES NEEDED MORE MONIES TO OPERATE AN EFFICIENT AND EFFECTIVE PROGRAMS, SENIOR CITIZENS

CENTERS, TRANSPORTATION SERVICES AND AN OVERWHELMING SUPPORT OF THE TITLE VI DIRECTORS RECOMMENDATIONS FOR LEGISLATIVE AMENDMENTS FOR THE OLDER AMERICANS ACT AS ESTABLISHED IN THE MAY 1983 SIPI CONFERENCE.

THE RESULTS OF THE NOMINATIONS AND ELECTIONS FOR THE TWO (2) NATIONAL BOARD VACANCIES WERE AS FOLLOWING:

| | |
|---|---|
| MR. PRESTON KEEVAMA - SAN JUAN PUEBLO ELDER | 41 |
| MR. KENNETH SHUPLA - SANTA CLARA PUEBLO ELDER | 32 |
| MS. LAURA GRAHAM - DIRECTOR, SOCIAL SERVICES DIVISION LAGUNA RAINBOW CORPORATION | 63 |
| MR. MARTIN BIRD - CHAIRMAN, NEW MEXICO TITLE VI COALITION | 185 |

THE CONFERENCE WAS ADJOURNED APPROXIMATELY AN HOUR BEHIND SCHEDULE. IN CLOSING THE CONFERENCE WAS VERY SUCCESSFUL, IN THAT THE ELDERS WERE HAPPY WITH THE TURN OF EVENTS, THEIR ACTIVE INVOLVMENT IN THE ACTIVITIES AND THE RECOMMENDATIONS WHICH STEMMED FROM THE GATHERING. THE ELDERS REQUESTED THE TWO ELECTED OFFICIALS TAKE THE RECOMMENDATIONS TO THE NATIONAL AGING CONFERENCE TO BE HELD IN TULSA, OKLAHOMA MARCH 28 AND 29, 1984, AND REPRESENT THE ENTIRE NEW MEXICO OLDER INDIANS. THESE SAME TWO (2) DELEGATES TO MEET WITH THE NATIONAL BOARD MEMBERS AND OBTAIN THEIR SUPPORT FOR NEW MEXICO'S EFFORTS AND THE EFFORTS OF THOSE TITLE VI DIRECTORS PRESENT AT THE SIPI CONFERENCE IN MAY 1983.

FUNDS AND ARRANGEMENTS HAVE BEEN MADE AVAILABLE FOR THE TRIP TO TULSA, OKLAHOMA THROUGH MONIES GENERATED FOR THE MARCH 16th. CONFERENCE IN SANTA FE. FURTHERMORE, I HAVE MADE FLIGHT ARRANGEMENTS TO LEAVE FROM ALBUQUERQUE ON TUESDAY, MARCH 27th. AT 9:40

AM AND DUE TO RETURN ON THURSDAY, MARCH 29, 1984. YOUR SUPPORT AND WELL WISHES FOR A SUCCESSFUL TRIP IS ANTICIPATED. FURTHERMORE, HOPEFULLY THROUGH THE BLESSINGS OF THOSE THAT EACH OF YOU REPRESENT, THEY WILL OPEN UP AND PAVE THE PATH FOR OUR EFFORTS IN COMMUNICATING WITH THOSE WHO ARE RESPONSIBLE FOR ALLOCATIONS AND INDIAN PROGRAMS. A REPORT WILL BE SUBMITTED UPON MY RETURN FOR YOUR RECORDS.

THE NEXT VERY IMPORTANT EVENTS THAT WILL BE UPCOMING IS SCHEDULED IN WASHINGTON, D.C. DURING APRIL 3 thru 5, 1984. THIS WILL BE THE NEXT LINKAGE OF THE LONG PROCESS OF EVENTS PARTICIPATED BY OUR ELDERS. A NATIONAL CONFERENCE IS PLANNED TO ADDRESS CONCERNS AND ISSUES FOR THE REAUTHORIZATION OF THE OLDER AMERICANS ACT IN CONGRESS LATER THIS SUMMER. MANY OF THE STATES OLDER PEOPLE (TO INCLUDE INDIANS) ARE PLANNING A CARAVAN TO WASHINGTON, D.C. TO MEET, DISCUSS AND OBTAIN POSITIONS BY OUR ELECTED OFFICIALS AT THE NATIONAL LEVEL FOR THE PROPOSED REAUTHORIZATION OF THE ACT.

# SECOND ANNUAL
# NEW MEXICO INDIAN CONFERENCE
# ON AGING
# GREER GARSON THEATER - COLLEGE OF SANTA FE

SANTA FE, NEW MEXICO

FRIDAY - MARCH 16, 1984

## AGENDA

| | |
|---|---|
| 8:00 AM - 9:00 AM | REGISTRATION AND COFFEE |
| 9:30 AM - 9:30 AM | OPENING BY: MARTIN BIRD, CHAIRMAN NEW MEXICO TITLE VI COALITION<br>INVOCATION BY: MR. DON MERMEJO, ELDERLY PICURIS PUEBLO<br>INTRODUCTION OF DIGNITARIES AND SPECIAL GUESTS BY: MARTIN BIRD<br>WELCOME AND OPENING BY: LORENCITA VERMILLION, CHAIRWOMAN NEW MEXICO INDIAN COUNCIL ON AGING |
| 9:30 AM - 10:30 AM | GENERAL SESSION - GUEST SPEAKERS<br>1. DR. JOSEPH GOLDBERG - SECRETARY NEW MEXICO HUMAN SERVICES DEPARTMENT<br>2. MR. GEORGE ELLIS, DIRECTOR NEW MEXICO STATE AGENCY ON AGING<br>3. MR. SEFERINO TENORIO - EXECUTIVE DIRECTOR AND OWNER - NATIVE AMERICAN MANAGEMENT AND EDUCATION SERVICES<br>4. MR. RAMUS SUINA - DEPUTY DIRECTOR OFFICE OF INDIAN AFFAIRS<br>5. MR. ERNESTO RAMOS - DIRECTOR NEW MEXICO STATE ACTION OFFICE |
| 10:30 AM - 10:45 AM | BREAK AND EXERCISE |
| 10:45 AM - 12:00 PM | CONTINUE GENERAL SESSION WITH SPEAKERS |
| 12:00 PM - 1-30 PM | LUNCH |

| | |
|---|---|
| 1:30 PM - 2:00 PM | ENTERTAINMENT - INDIAN GROUPS |
| 2:00 PM - 3:00 PM | GROUP SESSIONS<br>BREAK INTO INDIVIDUAL TRIBES<br>(SELECT A SPOKESPERSON/S) |
| 3:00 PM - 4:00 PM | TRIBAL TESTIMONY AND/OR RECOMMENDATIONS |
| 4:00 PM - 4:30 PM | CLOSING SESSION BY: MARTIN BIRD |
| | BENEDICTION BY: JULIAN CHINO, ELDERLY<br>ACOMA PUEBLO |
| | ADJOURNMENT: MARTIN BIRD |

## NEW MEXICO INDIAN TRIBES
## ELDERLY NEEDS BY TRIBE

MARCH - 1984

### ACOMA PUEBLO

1. DIRECT FEDERAL FUNDING TO ALL INDIAN TRIBES.
2. LONG TERM CARE FACILITY FOR ELDERLY.
3. SOCIAL SECURITY AND PENSIONS FOR ELDERLY.
4. TITLE V AND SENIOR COMPANION PROJECTS TO BE CONTINUED FOR TRIBES.
5. TOTALLY SUPPORT TITLE VI PROPOSED RECOMMENDATIONS FOR FUTURE FUNDING AND IMPROVEMENTS.

### COCHITI PUEBLO

1. ADDITIONAL FUNDING FOR ENERGY PROGRAMS.
2. ADDITIONAL FUNDING TO INCREASE TITLE VI SERVICES, MEALS AND STAFFING.
3. SUPPORT TITLE VI PROPOSED RECOMMENDATIONS.

### EIGHT NORTHERN INDIAN PUEBLOS, CORP.

1. SUPPORT INCREASE OF TITLE VI FUNDING TO $50 MILLION.
2. NEED FOR LARGER FACILITIES.
3. ADDITIONAL MONIES TO HIRE PERMANENT STAFF.
4. BETTER ASSISTANCE AT THE IHS-PHS HEALTH UNITS FOR INDIAN ELDERS.
5. CENTRALLY LOCATED NURSING HOME FACILITY.
6. LARGER FACILITIES FOR SENIOR CENTERS.

LAGUNA PUEBLO

1. STRONGLY RECOMMEND AND SUPPORT TITLE VI PROPOSED AMENDMENTS.

SANDIA PUEBLO

1. CONTRUCT AND EQUIP A NEW SENIOR CENTER.
2. NEED OF A VAN FOR TRANSPORTATION SERVICES.
3. ADDITIONAL MONIES FOR ENERGY ASSISTANCE PROGRAM.
4. STRONGLY SUPPORT TITLE VI RECOMMENDATIONS.

ISLETA PUEBLO

1. SUPPORT INCREASE OF TITLE VI FUNDING-REAFFIRM THE SUPPORT TOWARDS PROPOSED TITLE VI LEGISLATION FOR 1985.
2. ESTABLISH AN INDIAN DESK IN WASHINGTON, D.C.
3. EXPRESS DISAPPOINTMENT TO THE NATIONAL INDIAN COUNCIL ON AGING (NICOA) FOR NOT PROPERLY REPRESENTING TITLE VI GRANTEES AND INDIAN ELDERLY IN GENERAL.

SANTA ANA PUEBLO

1. ADDITIONAL MONIES FOR ADDITIONAL FULL TIME STAFF.
2. ADDITIONAL MONIES FOR PURCHASE OF MODERN KITCHEN EQUIPMENT AT NUTRITION SITE.
3. ADDITIONAL MONIES TO FEED FIVE (5) DAYS PER WEEK.

JICARILLA APACHE TRIBE

STRONGLY SUPPORT TITLE VI RECOMMENDATIONS.
ESTABLISH AN INDIAN DESK WITHIN AoA IN WASHINGTON.
MORE MONIES FOR ENERGY CRISIS PROGRAM.
UNCOMPLICATE RULES AND REGULATIONS FOR COORDINATED COM-

4. MUNITY IN HOME CARE PROGRAM (CCIC STATE FUNDED PROGRAM).

JEMEZ PUEBLO

1. SENIOR CENTER WITH COMPLETE MODERN EQUIPMENT.
2. ADDITIONAL MONIES TO HIRE PERMANENT STAFF.
3. ADDITIONAL MONIES FOR ENERGY ASSISTANCE PROGRAM.
4. SUPPORT TITLE VI PROPOSED RECOMMENDATIONS.

ZUNI PUEBLO

1. NEED FOR A NEW SENIOR CENTER.
2. NEED FOR COMPLETE AND MODERN KITCHEN EQUIPMENT.
3. MONIES TO PURCHASE A VAN.
4. ADDITIONAL MONIES TO PROVIDE MORE SERVICES TO ELDERS.
5. OPERATIONAL FUNDS FOR SPECIALIZED UNITS FOR THE ELDERLY PEOPLE FOR LONG TERM CARE.
6. SUPPORT THE PROPOSED TITLE VI RECOMMENDATIONS FOR FUTURE FUNDING OF INDIAN AGING PROGRAMS.

ZIA PUEBLO

1. ADDITIONAL FUNDS TO OPERATE FIVE (5) FULL DAYS OF NUTRITIONAL AND SUPPORTIVE SERVICES.
2. MORE MONIES FOR THE ENERGY ASSISTANCE PROGRAM FUNDING.
3. NEED FOR A SMALL BUS AND A NEW VAN.
4. NEED FOR A NEW SENIOR CITIZENS CENTER.

SANTO DOMINGO PUEBLO

1. FULLY EQUIPPED SENIOR CITIZENS CENTER TO BE LOCATED WITHIN THE RESERVATION AND CLOSE TO THE VILLAGE FOR ELDERLY ACCESS.

2. A TWENTY FOUR (24) HOUR FULLY EQUIPPED NURSING HOME TO SERVE THE COMMUNITY FRAIL AND DISABLED ELDERLY.
3. NEED OF A NEW 15 PASSENGER VAN.
4. NEED OF A NEW SCHOOL BUS TYPE FOR USE WITHIN THE VILLAGE.
5. PURCHASE A COACH TYPE BUS FOR EXTENDED TRIPS - EQUIPPED WITH A RESTROOM, SOFT CUSSHIONED SEATS AND LUGGAGE COMPARTMENT FOR EXTENDED TRIPS.
6. CONTINUE AND IMPROVE VETERANS BENEFITS SERVICES TO ALL INDIANS OF ALL AGES.
7. CONTINUE SOCIAL SECURITY BENEFITS - WHICH MOST ELDERLY INDIANS ARE DEPENDENT UPON LIKE MILLIONS OF OTHER AMERICANS IN THIS COUNTRY.
8. TOTALLY SUPPORT TITLE VI PROPOSED LEGISLATIVE AMENDMENTS FOR IMPROVED SERVICES FOR ALL INDIAN ELDERS.
9. IMPROVE COORDINATION OF ALL AGENCIES AT THE STATE, REGIONAL AND FEDERAL LEVELS IN BRINGING ABOUT IMPROVED SERVICES TO ALL OLDER AMERICANS.
10. CONTINUE FUNDING FOR ENERGY ASSISTANCE AND CRISIS PROGRAMS AND WEATHERIZATION SERVICES.

SPECIAL NOTATION:

- MESCALERO APACHE TRIBE, SAN FELIPE PUEBLO TRIBE AND THE NAVAJO NATION WERE NOT REPRESENTED AT MARCH 16, 84 CONFERENCE IN SANTA FE, NEW MEXICO.
- SAN FELIPE IS INTERESTED IN IMPLEMENTING AN AGING PROGRAM AND WILL BE SUBMITTING APPLICATION PACKAGE FOR FUNDING.

* EIGHT NORTHER TRIBES-NAMBE, PICURIS, POJOAQUE, SAN ILDEFONSO, SAN JUAN, SANTA CLARA, TAOS AND TESUQUE.

# Program for the New

# Santo Domingo Community Health Center

B. Corken - Design Planning Assistance Center

Santo Domingo Community Health Center

Program - Santo Domingo Pueblo

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Santo Domingo Community Health Center

Program - Santo Domingo Pueblo

## Forword

This document contains information that will be used as a guide in developing a Community Health Center for the Santo Domingo Pueblo Tribe located in the State of New Mexico. The proposed Community Health Center will provide medical/ dental outpatient services, elderly housing and an alcohol treatment program. The porgram information specifies the type and quanity of space and functional considerations among spaces.

Data for this document, including detailed staffing and planning assumptions for the proposed Health Center will be found in a companion doucument, "Program Information, Santo Domingo Health Clinic," prepared by the Indian Health Service.

## Scope

Santo Domingo Pueblo is located in the Rio Grande Valley, Sandoval County, approximately half-way between Albuquerque and Santa Fe. The community lies to the east of the Rio Grande River within a reservation of some 69,000 acres.

The existing health facility was built in 1963 with a dental addition in 1968. Due to greater medical needs brought on by the pueblos rising population, the construction of a new facility is necessary to provide adequate space and additional services. A modern health clinic will include full outpatient diagnostic and treatment facilities, optometry services, mental health and social services, environmental health, nutrition counseling and community health nursing. The comprehensive health services provided at this facility will also include dental services, an alcohol treatment program and elderly housing services.

The total area programmed in this document equals 36,904 gross square feet. This compares with the present 1,928 gross square feet contained in the existing facility. The design concept seeks to provide an environment which is in character and scale with the culture for the Indian people served by this facility and should create an atmosphere for patient care which is conducive to their personal well being.

## Site

The proposed site is away from the main village of Pueblo but is on the reservation. It is near the Santo Domingo school on Route #32 off of Route #25.

Santa Domingo Community Health Center

Program - Santo Domingo Pueblo p. 4

**Facts**

Summary Space Schedule

**Medical/Dental Outpatient**

| | | |
|---|---|---|
| 1100 : Administration | | |
| -Office Sapce | 4@ 120 | 480 |
| -Secretary Area/Filing | | 500 |
| -Duplication & Mail | | 120 |
| | | 1100 sq. ft. |
| 400 : Building Services | | |
| -Storage | | 120 |
| -Mechanical | | 120 |
| -Receiving | | 160 |
| | | 400 sq. ft. |
| 500 : Consulting/Training | | |
| -Conference Room | | 500 sq. ft. |
| 1080 : Dental | | |
| -Dental Operatory | 4@ 120 | 480 |
| -Support Office | | 120 |
| -Storage/Clean-up | | 60 |
| -Office/Public Area | | |
| -Reception/Waiting | | 300 |
| -Office, Dentist | | 120 |
| | | 1080 sq. ft. |
| 450 : Employee Facilities | | |
| -Mens & Womens Comfort Areas | | 450 sq. ft. |

**Facts**

Summary Space Schedule (con't.)

Medical/Dental Outpatient

| | | | |
|---|---|---|---|
| 1840 | : Field Health | | |
| | -Offices | 7@ 120 | 840 |
| | -Secretary/Filing | | 1000 |
| | | | 1840 sq. ft. |
| 120 | : Health Records | | |
| | -Work Area | | 120 sq. ft. |
| 440 | : Laboratory | | |
| | -Chemistry | | 120 |
| | -Hematology | | 120 |
| | -Microbiology | | 120 |
| | -Specimen Toilets | | 80 |
| | | | 440 sq. ft. |
| 900 | : Lobby | | |
| | -Lobby/Waiting | | 800 |
| | -Reception/Information | | 100 |
| | | | 900 sq. ft. |
| 1360 | : Outpatient Services | | |
| | Treatment | | |
| | -Physicians office | 2@ 120 | 240 |
| | -Examination Room | 6@ 90 | 540 |
| | Public & Support | | |
| | -Nurses Station/Office | | 110 |
| | -Toilet | | 40 |
| | -Drugs | | 40 |
| | -Closet | | 40 |
| | -Waiting/Reception | | 350 |
| | | | 1360 sq. ft. |

**Facts**

Summary Space Schedule (con't.)

**Medical/Dental Outpatient**

400 : Pharmacy

| | | |
|---|---|---|
| -Pharmacy | | 240 |
| -Dispensing | | 40 |
| -Office | | 120 |
| | | 400 sq. ft. |

520 : Radiology

| | | |
|---|---|---|
| -Radiology | | 400 |
| -Office | | 120 |
| | | 520 sq. ft. |

**Alcohol Treatment**

2500 : Inpatient

| | | |
|---|---|---|
| -Waiting | | 375 |
| -Detoxification | | 625 |
| -Nurses Office/station | | 180 |
| -Womens Rooms | 3@120 | 360 |
| -Mens Short Term Rooms | 2@180 | 360 |
| -Mens Long Term Rooms | | 540 |
| -Closet | | 50 |
| | | 2500 sq. ft. |

2900 : Outpatient

| | | |
|---|---|---|
| -Offices | 4@120 | 480 |
| | 2@240 | 480 |
| -Conference Room | | 1000 |
| -Activity Room | | 400 |
| -Waiting/Reception | | 540 |
| | | 2900 sq.ft. |

**Facts**

Summary Space Schedule (con't.)

**Elderly Housing**

5450 : Phase I

| | | |
|---|---|---|
| -Units w/Toilets | 6@ 280 | 1680 |
| -Double Units w/Toilets | 2@ 560 | 1120 |
| -Commons Areas | 2@ 400 | 800 |
| -Dining | | 1650 |
| -Storage | 2@ 100 | 200 |
| | | 5450 sq. ft. |

3960 : Phase II

| | | |
|---|---|---|
| -Units w/Toilets | 12@ 280 | 3360 |
| -Commons Areas | 2@ 300 | 600 |
| | | 3960 sq. ft. |

Toilet Space as required by program and design.

**Facts**

Activities and Schedules

. Outpatient - Medical/Dental and Alcoholic

The outpatient services provided at the proposed health center will treat such cases as would not require specialized, highly technical equipment or training and those cases which are of an immediate or emergency nature. In addition, examinations and periodic check-up/treatment care will be stressed as part of a preventive medical program.

These services will be offered through both the medical and dental programs and will provide a comprehensive outpatient program that will function to serve the majority of the pueblos medical needs. Any case of a nature that can not be handled at the new facility will be referred to Santa Fe Hospital.

The Alcohol Treatment Outpatient Program shall offer a therapy/counseling program for patients requiring those services. This program shall operate with six counselors under the direction of a supervisor. Each counselor will have a load of patients: approximately forty patients per counselor. Patients begin therapy with individual interviews and then are put into group sessions of six to eight patients per group.

Group sessions will be scheduled to best suit the needs of the patients. Counselor work shifts will be determined by their group session hours and the patients available time. The counselors

**Facts**

Activities and Schedules

Outpatient - Alcohol Treatment (con't.)

will also teach alcohol abuse education classes with a special emphasis to women and adolescent alcohol abuse programs. Due to their high patient loads, counselors require a large individual office space with the ability to expand for larger group situations.

An Alcohol Anti-abuse Program will also be set up to work in conjunction with the Alcohol Outpatient Clinic if it is determined to be in the best interests of the individual patient. Anti-abuse is a substance which reacts with alcohol making it very difficult for a patient taking the drug to ingest alcohol.

Inpatient - Alcohol Treatment

The Inpatient Program is a medical facility under the supervision of a doctor and a nursing staff. The facility will provide for the detoxification of patients, and, if necessary, medical care is available. The facility will also provide beds for short term or long term (one to two weeks) accomodations allowing for live-in treatment if the patients needs call for it.

The staff will interview and examine all patients upon entry and then if they are admitted for a longer duration the staff will provide for the care and feeding of the patients. Medical records will be kept on all patients admitted to both programs.

**Facts**

Activities and Schedules

Inpatient - Alcohol Treatment

The Inpatient staff will be composed of ten to twelve people. The daytime shift will consist of two secretaries, a receptionist, a doctor that shall work through the Medical Center, and the administrative director. The nurses and other staffers then will work rotational schedules to provide service round the clock.

Upon entry into Inpatient, the patient is admitted to detoxification for a physical examination and interview. If his health is extremely poor or if there is any evidence of some health disorder he shall be admitted to the Medical Center or sent to Santa Fe Hospital. Otherwise, after sobered up he will be released or admitted into the program. There are two live-in accomodations at the Inpatient Facility: Short(emergency) or long-term. Each room will have its own bathroom. All women's accomodations are afforded protection from intrusion by male patients.

The interview room, detoxification, must accomodate two or three simultaneous interviews, providing privacy for each patient and room enough for families in the interview area.

Elderly Housing

The elderly housing facilities attached to the Community

## Facts

### Activities and Schedules

### Elderly Housing

Health Center shall provide housing accomodations for elderly residents who do not require much special attention. The housing plan is in two distinct phases: Phase II to be added on as the need arises.

The units are designed to accomodate residents confined to a wheelchair, incorporating fixtures designed for this purpose and the spaces shall allow for the easy access of ambulatory and non-ambulatory residents.

Dining and laundry services shall be provided for the residents, meals will be served in a communal dining room. Other communal spaces indoor and outdoor courtyards, will give areas for activities and conversation and shall be of a manner indigenous to the local surroundings.

There will also be a pair of double units for roomate accomodations.

## Goals

Function:

Important points for consideration in the design of the new Santo Domingo Community Health Center.

* Separation of function: all administrative, technical, medical, staff, professional and residence shall be situated to take advantage of its functionally coresponding support areas, ie. medical to technical, exam room to laboratory, however each shall be treated as separate and distinct zones.

* Privacy: Individual patient or resident privacy will be afforded as much as possible in all aspects of treatment. For example, an alcohol treatment patient shall be afforded privacy and respectful treatment upon his entry into Detoxification, and then will be afforded individual treatment and privacy as much as can be made available in his sleeping quarters.

* The Health Center must fit in with the local vernacular.

* The Health Center must be comfortable and non-institutional while portraying a professional attitude and the best possible treatment and care.

* The Elderley Housing must be warm and inviting and be a place people will want to live.

design & planning
assistance center
120 YALE SE, ALBUQUERQUE, NEW MEXICO, 87106 – (505) 277-3806 or 3647
UNIVERSITY OF NEW MEXICO SCHOOL OF ARCHITECTURE & PLANNING

## COST ESTIMATES -- SANTO DOMINGO PUEBLO

**PROJECT NAME:** ELDERLY HOUSING - PHASE II

1. **BUILDING COSTS:**

3960 (no.) sq. ft. x 60 (dollars) sq. ft. $ 237,600

2. **SITE DEVELOPMENT:**

12 (%) x 237,600 (Building Costs) $ 28512

3. **EQUIPMENT:**

_____ (%) x _____ (Building Costs) $ 30,000

(A) (SUBTOTAL) $ 296,112

4. **CONTINGENCY:**

10 (10%) x 296,112 (Subtotal - A) $ 29,611

(B) (SUBTOTAL) $ 325,723

5. **PROFESSIONAL FEES:**

12 (%) x 325,723 (Subtotal - B) $ 39,086

(C) (SUBTOTAL) $ 364,809

6. **CONTRACTORS OVERHEAD AND PROFIT:**

20 (20%) x 364,809 (Subtotal C) $ 72961

(TOTAL) $ 437,770

**ESCALATION**

Above costs are good for 30 days, thereafter add 15% per annum.

design & planning
assistance center
180 YALE SE, ALBUQUERQUE, NEW MEXICO, 87106 - (505) 277-3806 or 3647
UNIVERSITY OF NEW MEXICO SCHOOL OF ARCHITECTURE & PLANNING

## COST ESTIMATES -- SANTO DOMINGO PUEBLO

**PROJECT NAME:** ELDERLY HOUSING- PHASE I

1. **BUILDING COSTS:**

5450 (no.) sq. ft. x 60 (dollars) sq. ft. $ 327,000
4500 100 45,000
372,000

2. **SITE DEVELOPMENT:**

12 (%) x 372,000 (Building Costs) $ 44,640

3. **EQUIPMENT:**

____ (%) x ____ (Building Costs) $ 50,000

(A) (SUBTOTAL) $ 466,640

4. **CONTINGENCY:**

10 (10%) x 466,640 (Subtotal - A) $ 46,664

(B) (SUBTOTAL) $ 513,304

5. **PROFESSIONAL FEES:**

12 (%) x 513,304 (Subtotal - B) $ 61596

(C) (SUBTOTAL) $ 574,900

6. **CONTRACTORS OVERHEAD AND PROFIT:**

20 (20%) x 574,900 (Subtotal C) $ 114,980

(TOTAL) $ 689,880

**ESCALATION**

Above costs are good for 30 days, thereafter add 15% per annum.

design & planning assistance center
120 YALE SE, ALBUQUERQUE, NEW MEXICO, 87106 – (505) 277-3806 or 3647
UNIVERSITY OF NEW MEXICO SCHOOL OF ARCHITECTURE & PLANNING

## COST ESTIMATES -- SANTO DOMINGO PUEBLO

**PROJECT NAME:** COMMUNITY HEALTH CENTER

1. **BUILDING COSTS:**

4000 (no.) sq. ft. x $100. (dollars) sq. ft. $ 400,000
19,190 $60. 1,151,400
1,551,400

2. **SITE DEVELOPMENT:**

12 (%) x 1,551,400 (Building Costs) $ 186,168

3. **EQUIPMENT:**

(%) x (Building Costs) $ 319,400

(A) (SUBTOTAL) $ 2,056,968

4. **CONTINGENCY:**

10 (10%) x 2,056,968 (Subtotal - A) $ 205,696

(B) (SUBTOTAL) $ 2,262,664

5. **PROFESSIONAL FEES:**

10 (%) x 2,262,664 (Subtotal - B) $ 226,664

(C) (SUBTOTAL) $ 2,489,328

6. **CONTRACTORS OVERHEAD AND PROFIT:**

20 (20%) x 2,489,328 (Subtotal C) $ 497,865

(TOTAL) $ 2,987,193

**ESCALATION**

Above costs are good for 30 days, thereafter add 15% per annum.

ALL INDIAN PUEBLO
HOUSING AUTHORITY
p.o. 35040 - station D albuquerque, new mexico 87176 [505] 766-3006

April 5, 1983

TO: Julian Coriz, Santo Domingo Commissioner

FROM: Courtney Moyah, Director

SUBJECT: ELDERLY COMPLEX

The following are general requirements that should be included in the design of an elderly complex.

SITE REQUIREMENTS

A location that provides for a quiet environment, and should have easy access to all weather type road or paved road.

A community septic system or sewer system.
A minimum height fence, 3'-4' Fence.
Ramps on sidewalks, no steps.
Parking area with good lighting - trash area
Fire Hydrants

Two Types of Building

A. Living Unit
B. Community Space

A. Dwelling Unit:
1. Can be 1 or 2 bedroom, difference in cost not that great. $100 additional room.
2. Bath - for handicap; rails, bars, seat in shower stall. No bath tubs.
3. Bedroom - Small and Convenient
   - Central alarm system - button or pull string.
   - Carpet in all rooms - except kitchen.
   - Light switches at wheelchair level.
   - Handles - No knobs on doors/kitchen fixtures.
   - Windows lower than normal for fire escape.
   - Lower fixtures in kitchen - wheelchair (cabinets and sink).
   - Trash deposal system (Exterior or Interior).
   - Fire Alarm - individual or centralized to Community Building.
   - Fire Extinguisher in kitchen area.

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B. Community Space:
  - Meeting area - chairs and table(s).
  - Small kitchen
  - Center for Alarm system - Bell or light indicators
  - Roll-a-bout Fire equipment - firehose and extinguisher.
  - Office space/maintenance room.
  - Examination Room
  - Handicap bathroom(s)
  - Small laundry
  - Small storage space
  - Sauna - if desired.
  - Centralized metering; water - electricity - gas (optional)

These are some of the basics. As you proceed forward with the planning and designing, please let me know if you require additional information. It sounds like a worthwhile project for your people.

cc: Domingo Atencio, Alternate

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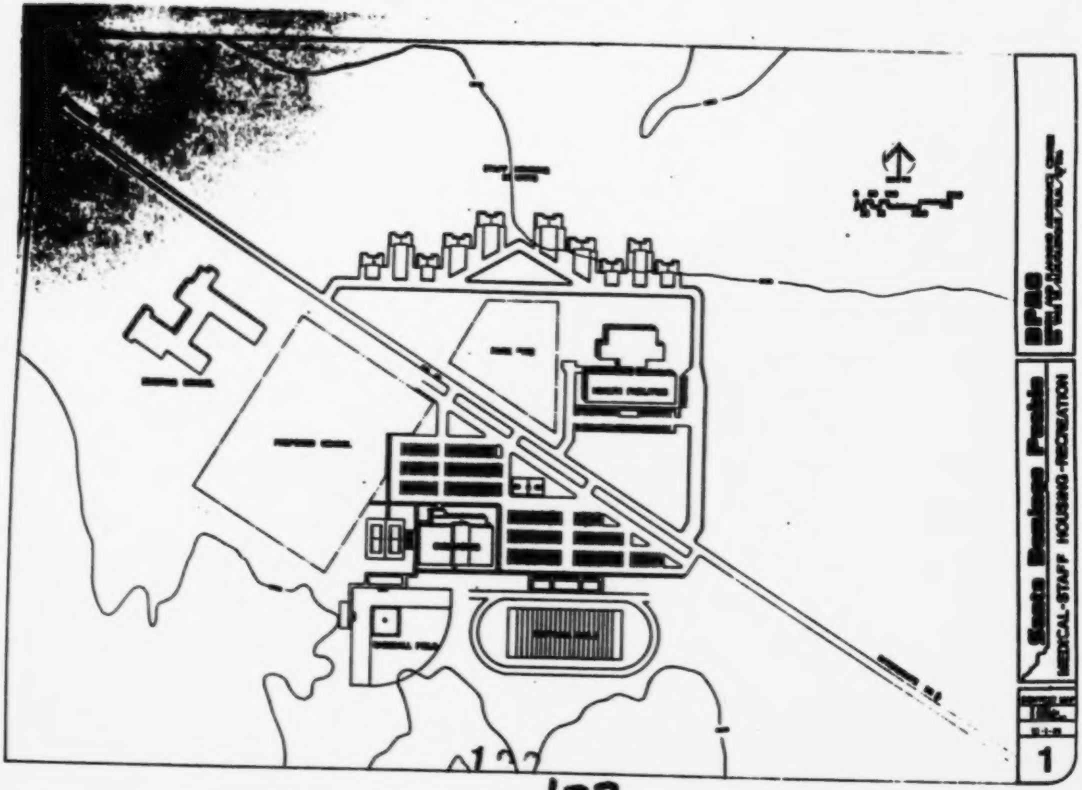
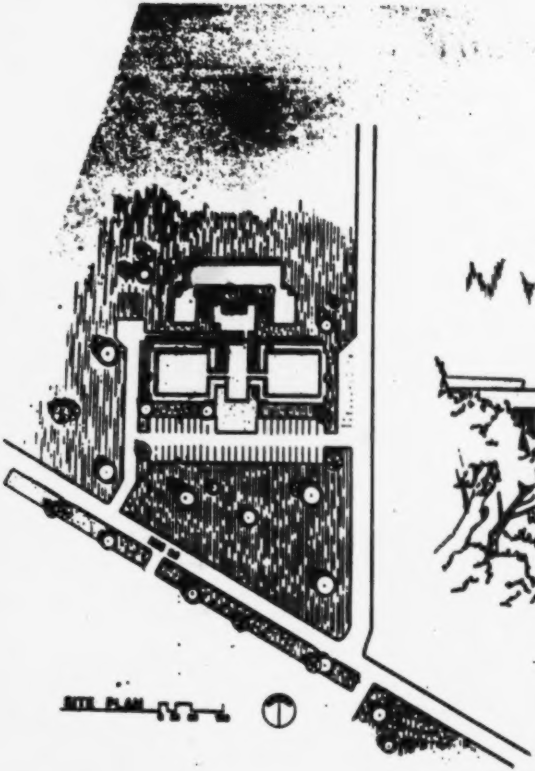
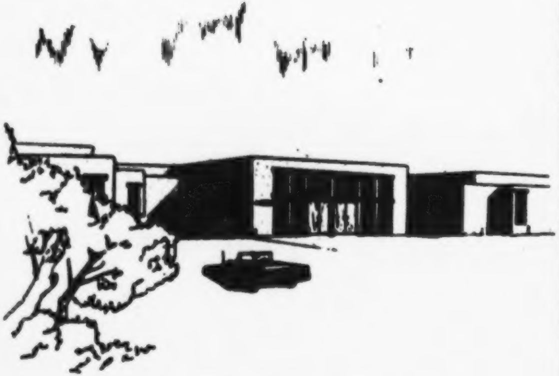

BPMC
Santo Domingo Pueblo
MEDICAL-STAFF HOUSING-RECREATION
1



SITE PLAN



VIEW TOWARDS ENTRY

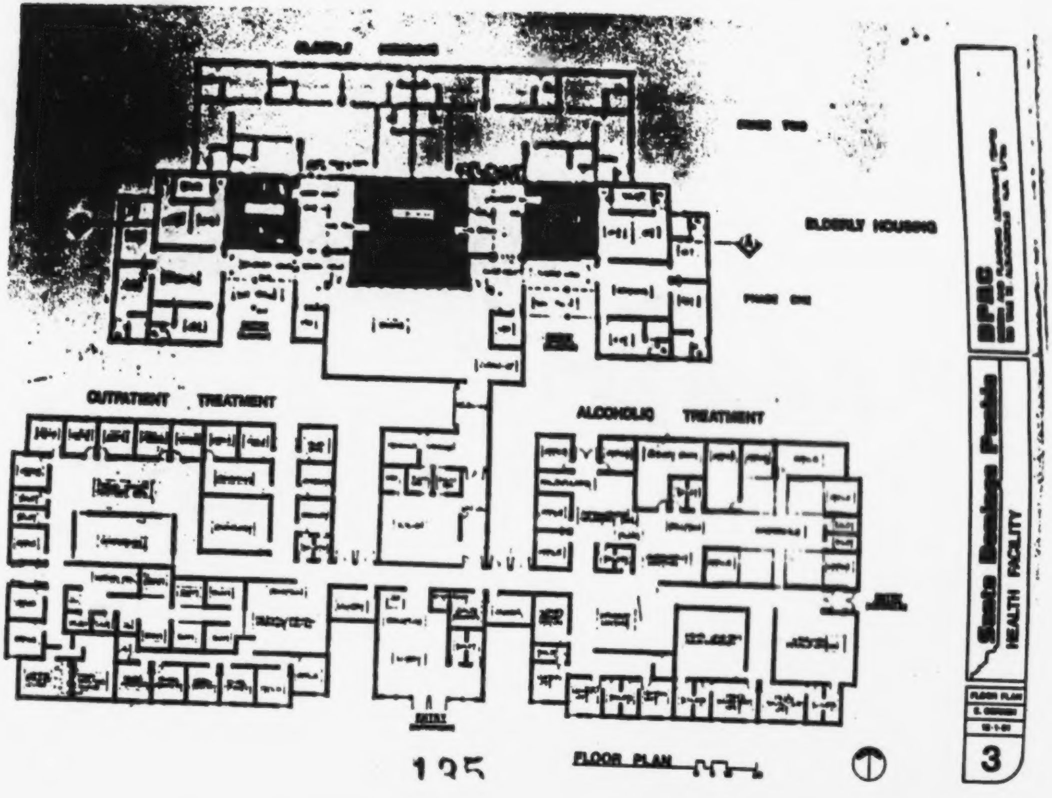
**SPSG**

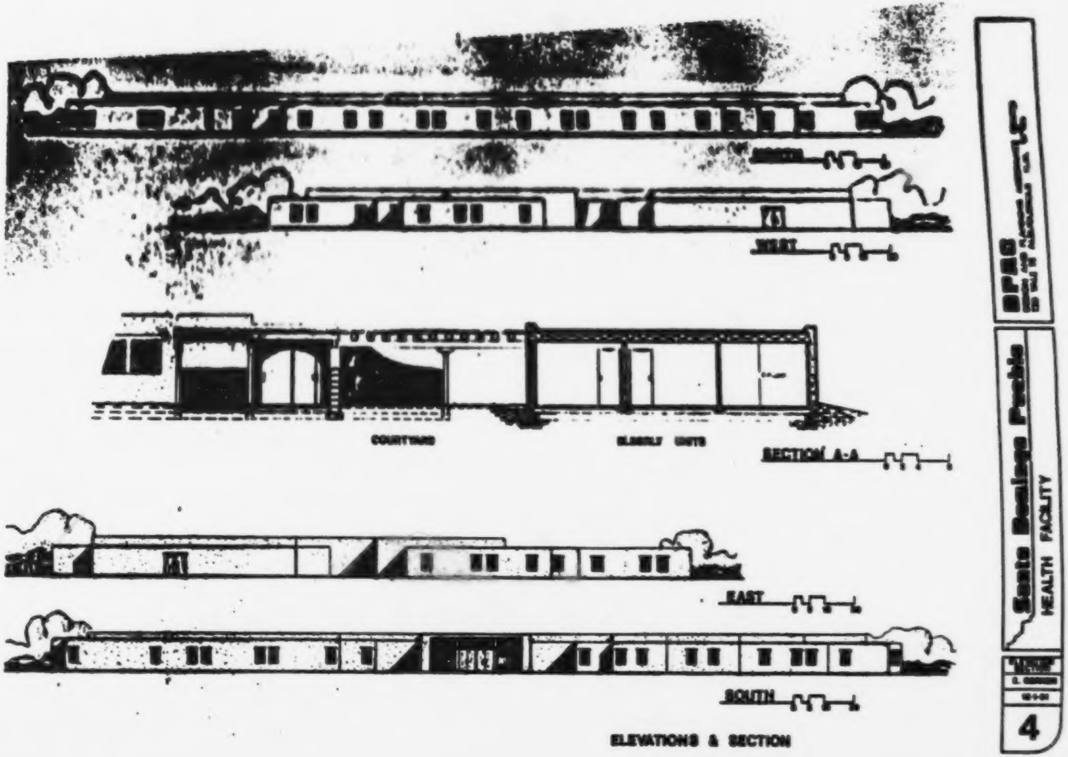
Santo Domingo Pueblo

HEALTH FACILITY

SITE PLAN

2


ELDERLY HOUSING
PHASE TWO
ELDERLY HOUSING
PHASE ONE
OUTPATIENT TREATMENT
ALCOHOLIC TREATMENT
ENTRY
FLOOR PLAN
DPRC
Santo Domingo Pueblo
HEALTH FACILITY
FLOOR PLAN
3


NORTH
WEST
COURTYARD
ELDERLY UNITS
SECTION A-A
EAST
SOUTH
DPAG
Santo Domingo Pueblo
HEALTH FACILITY
4

ELEVATIONS & SECTION

# TITLE VI - GRANTS FOR INDIAN TRIBES

## STATEMENT OF PURPOSE

Sec. 601 (a.) It is the purpose of this title to promote the delivery of social services, including nutritional services, for Indians that are comparable to services provided under title III.

(b.) Indians who reside in areas outside the Tribe's jurisdiction, shall be entitled to funding from the Area Agency on Aging within the Planning and Service Area under Title III. Area Agencies on Aging shall make assurances that Indian organizations within the PSA are included on advisory boards, planning committee and included in the allocation of funding.

(c.) The Administration on Aging shall establish an Indian Office on Aging that shall be assigned the responsibility of providing technical assistance, information, and policy directions to all Indian grantees under this title.

(d.) The Commissioner shall make provisions to implement an annual meeting of all grantees under this Title for the purposes of training and increasing the effective administration of the programs.

## ELIGIBILITY

Sec. 602 (a.) A tribal organization of an Indian tribe is eligible for assistance under this title if:

1.) individuals to be served by the tribal organization will not receive for the year for which application under this title is made, services under Title III.

2.) the tribal organization meets the definition of "Indian Tribe" and "Tribal Organization" as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

## GRANTS AUTHORIZED

Sec. 603 (a.) The commissioner may make grants to eligible tribal organizations to pay all of the costs for delivery of social services and nutritional services for older Indians.

(d.) (1) from the sum appropriated under Section 608, each Tribe shall be alloted a minimum level of $100,000 per fiscal year; (2) the remaining sums shall be allocated to each Tribe an amount which bears the same ratio to such sums as the population aged 55 or older in such Tribe bears to the population aged 55 or older in all Tribes.

## APPLICATIONS

Sec. 604 (a.) No grant may be made under this title unless the eligible tribal organization submits an application to the Commissioner which meets such criteria as the Commissioner may by regulation prescribe. Each such application shall:

1.) provide that the eligible tribal organization will evaluate the need for social and nutritional services among older Indians to be represented by the tribal organization;

2.) provide for the use of such methods of administration as are necessary for the proper and efficient administration of the program to be assisted;

3.) provide that the tribal organization will make such reports in such form and containing such information, as the Commissioner may reasonably require, and comply with such requirements as the Commissioner may impose to assure the correctness of such reports;

4.) provide for periodic evaluation of activities and projects carried out under the application;

5.) establish objectives consistent with the purposes of this title toward which activities under the application will be directed, identify obstacles to the attainment of such objectives, and indicate the manner in which the tribal organization proposes to overcome such obstacles;

6.) Provide for establishing and maintaining information and referral services to assure that older Indians to be served by the assistance made available under this title will have reasonably convenient access to such services;

7.) provide a preference for Indians aged 60 and older for full or part time staff positions wherever feasible;

8.) provide assurances that either directly or by way of grant or contract with appropriate entities nutritional services will be delivered to older Indians represented by the tribal organization substantially in compliance with the provisions of part C of title III, except that in any case in which the need for nutritional services for older Indians represented by the tribal organization is already met from other sources, the tribal organization may use the funds otherwise required to be expended under this paragraph for supportive services;

9.) contain assurances that the provisions of sections 307(a)(14)(A)(i) and (iii), 307(a)(14)(B), and 307(a)(14)(C) will be complied with whenever the application contains provisions for the acquisition, alteration, or renovation of facilities to serve as multipurpose senior centers;

10.) provide that any legal or ombudsman services made available to older Indians represented by the tribal organization will substantially in compliance with the provisions of title III relating to the furnishing of similar services;

11.) provide satisfactory assurance that fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the tribal organization, including any funds paid by the tribal organization to a recipient of a grant or contract; and;

12.) submit to the Commissioner plans for the provision of services to the elderly that shall cover a period of up to three years.

(b.) For the purpose of any application submitted under this title, the tribal organization may develop its own population statistics, with certification from the Bureau of Indian Affairs, in order to establish eligibility.

(c.) The Commissioner shall approve any applciation which complies with the provisions of subsection (a.).

(d.) Whenever the Commissioner determines not to approve an application submitted under subsection (a.) he shall:

1. state his objections in writing to the tribal organization within 60 days after such decision;
2. provide to the extent practicable technical assistance to the tribal organization to overcome his stated objections; and
3. provide the tribal organization with a hearing, under such rules and regulations as he may prescribe.

(e.) Whenever the Commissioner approves an application of a tribal organization under this title, funds shall be awarded for not less than 12 months, during which time such tribal organization may not receive funds under title III.

## ADMINISTRATION

Sec. 605. In establishing regulations for the purpose of this title the Commissioner shall consult with the Secretary of the Interior.

## SURPLUS EDUCATIONAL FACILTIES

Sec 606. (a.) Notwithstanding any other provision of law, the Secretary of the Interior through the Bureau of Indian Affairs shall make available surplus Indian educational facilities to tribal organizations, and nonprofit organizations with tribal approval, for use as multipurpose senior centers. Such centers may be altered so as to provide extended care facilities, community center facilities, nutritional services, child care services, and other social services.

(b.) Each eligible tribal organization desiring to take advantage of such surplus facilities shall submit an application to the Secretary of the Interior at such time and in such manner, and containing or accompanied by such information as the Secretary of the Interior determines to be necessary to carry out the provisions of this section.

## SENIOR EMPLOYMENT

Sec. 607 (a.) The Commissioner shall develop and implement a contract with the National Indian Council on Aging to provide Title V services on a national basis; provided that no more than 5% of such sums as are appropriated are used for the administration of this program.

(b.) There shall be appropriated for Fiscal Years 1985, 1986, and 1987, thirty million dollars ($30,000,000) to implement the provisions of this subsection.

## PAYMENTS

Sec. 608. Payments may be made under this title (after necessary adjustments, in the case of grants, on account of previously made overpayments or underpayments) in advance or by way of reimbursement in such installments and on such conditions, as the Commissioner may determine.

## AUTHORIZATION OF APPROPRIATIONS

Sec. 609. There are authorized to be appropriated $50,000,000 for fiscal year 1985, $60,000,000 for fiscal year 1986, and $70,000,000 for fiscal year 1987 to carry out the provisions of this title.

## NATIONAL TITLE VI MEETING

## ATTENDANCE ROSTER

## MAY 12 & 13, 1983

| | NAME | ADDRESS/PHONE # |
|---|---|---|
| * 1. | lyonne Garreau, Proj. Dir. | Title VI Program<br>Cheyenne River Souix Tribe<br>Box 784<br>Eagle Butte, S. D. 57625<br>(605) 964-8056 |
| 2. | Janice K. Narango,CNC | Title VI Program<br>Pueblo of Santa Clara<br>P. O. Box 1598<br>Espanola, N. M. 87532<br>(505) 753-7326 |
| 3. | Regina A Quanchello, CNC | Title VI Program<br>Pueblo of Picuris<br>P. O. Box 228<br>Penasco, N. M. 87553<br>(505) 587-2711 |
| 4. | Juanita Garcia,Outreach | Title VI Program<br>Pueblo of Santo Domingo<br>P. O. Box 9<br>Santo Domingo, N.M. 87052<br>(505) 465-2214 Ext. 34 |
| 5. | Sheryl A Peters, Bookkeeper | Title VI Program<br>Pueblo of Santo Domingo<br>P. O.Box 9<br>Santo Domingo, N.M. 87052<br>(505) 465-2214 Ext. 27 |
| 6. | Adelita Calabaza, Outreach | Title VI Program<br>Pueblo of Santo Domingo<br>P. O. Box 9<br>Santo Domingo, N.M. 87052<br>(505) 465-2214 Ext. 34 |
| 7. | Given Grayson, Manager | Cherokee Nation Human Services<br>P. O. Box 948<br>Tahlequah, Oklahoma 74464<br>(918) 456-0671 |

| | |
|---|---|
| 8. Jeannie Lunsford, Manager | Chichasaw Nation Human Services<br>Chichasaw Tribal Office<br>P. O. Box 1548<br>Ada, Oklahoma 74820<br>(405) 436-2603 |
| 9. Sam Stool Jr., Coordinator | Cherokee Nation Elderly Programs<br>P. O. Box 948<br>Tahlequah, Oklahoma 74464<br>(918) 456-0671 |
| * 10. Mary S. Callison, Director | Title VI Program<br>Pawnee Tribe<br>Box 470<br>Pawnee, Oklahoma 73058<br>(918) 762-3759 |
| 11. Marcia Maltsberger, Cook | Muckleshoot Senior Center<br>39015 172nd. Ave., S. E.<br>Auburn, Washington 98002<br>(206) 939-3311 Ext. 23 |
| 12. Karen Housley, Director | Muckleshoot Title VI Program<br>39015 172nd. Ave., S. E.<br>Auburn, Washington 98002<br>(206) 939-3311 Ext. 23 |
| 13. Theymeus B. Vigil, Secr./Bkkpr. | Jicarilla Apache Title VI Prog.<br>Box 125<br>Dulce, N. M. 87528<br>(505) 759-3617 |
| 14. Laura Graham, Director | Social Services Division<br>Laguna Rainbow Corporation<br>Box 236<br>New Laguna, N. M. 87038<br>(505) 552-6035 |
| 15. Everett Routzen, Director | Acoma Title VI Program<br>P. O. Box 475<br>Acoma, N. M. 87034<br>(505) 552-6316 |
| 16. Agnes Smith, Director | Chippewa Tribe Title VI Prog.<br>Route #1, Box 92<br>Couderay, Wisconsin 54828<br>(715) 462-9364 |
| 17. Myrna Thayer, Director | Chippewa Tribe Title VI Prog.<br>Route #1, Box 92<br>Coudray, Wisconsin 54828<br>(715) 462-9364 |

ERIC

18. Vienna Badmilk, Director
Title VI Program
Oglala Souix Tribe
Box 132
Manderson, S. D. 57756
(605) 867-5913

* 19. Irene Malleck, Director
Winnebago Tribe Title VI Prog.
150 Market Avenue
Port Edwards, Wis. 54469
(715) 887-4150

20. Esther Abeita, Director
Pueblo of Isleta
Title VI Program
P. O. Box 317
Isleta, N. M. 87022
(505) 869-6661

21. Sue Dorme, CNC
Pueblo of Tesuque
Title VI Program
Route 11, Box 1
Santa Fe, N. M. 87501
(505) 982-9415

22. Florence Lujan, CNC
Pueblo of San Juan
Title VI Program
P. O. Box 1119
San Juan, New Mexico 87566
(505) 852-4516

23. Alfreida Haycock, Manager
Navajo Aging Services Dept.
Title VI Meal Site Oljato Utah
Box 278
Kayenta, Arizona 86033
(801) 727-3202

24. Emiliana Gadd, CNC
Pueblo of Nambe
Title VI Program
Route 1, Box 114-A
Santa Fe, N. M. 87501
(505) 455-2361

25. Julia Roybal, CNC
San Ildefonso Pueblo
Title VI Program
Route 5, Box 306
Santa Fe, N. M. 87501
(505) 455-7283

+ * 26. Janice Lopeman, Proj. Manager
Title VI Program
South Puget Planning
Shelton, Washington 98584
(206) 866-4081

+ denotes did not vote to approve recommended changes.

| | |
|---|---|
| 27. Matilda S. Juan, Director | Title III and VI Programs<br>Papago Tribe of Arizona<br>P. O. Box 837<br>Sells, Arizona 85634<br>(602) 383-2221 |
| 28. Tony V. Sanchez, Director | Title VI Program<br>Pascau Yaqui Tribe<br>4821 W. Calle Vicam<br>Tucson, Arizona 85706<br>(602) 883-6483 |
| 29. Walter McAtty, Director | Title VI Program<br>Nez Perce Tribe<br>Box 118<br>Lapwai, Idaho 83540<br>(208) 843-2253 Ext. 376 |
| 30. Rudolph King Sr., Director | Northern Cheyenne Title VI<br>Box 128<br>Lame Deer, Montana<br>(406) 477-6411 |
| 31. Frank Tenorio, Exec. Director | All Indian Pueblo Council, Inc.<br>Senior Companion Program<br>P. O. Box 6507<br>Albuquerque, N. M. 87197<br>(505) 247-0371 |
| 32. Betty White, Director | Yakima Indian Nation AAoA<br>P. O. Box 151<br>Toppenish, Washington 98948<br>(509) 865-5121 Ext. 484 |
| 33. Ellen M. Weston | Title VI Aging Program<br>Flandreau Santu Tribe<br>Flandreau, S. D. 57028<br>(605) 997-2440 |
| 34. Charles Henderson, Director | Navajo Aging Services Dept.<br>Windowrock Arizona Office<br>Box 331<br>Fort Defiance, Ariz. 86504<br>(602) 871-4941 Ext. 1797 |
| 35. Leon Roybal, Tribal Tres. | San Ildefonso Pueblo<br>Tribal Office Building<br>Route 5, Box 306<br>Santa Fe, N. M. 87501<br>(505) 455-2227 |

ERIC

| | |
|---|---|
| 36. Lawrence Birdsbill, Board Member | National Indian Council on Aging<br>Aberdeen Service Area<br>Box 747<br>New Town, N. D. 58763 |
| 37. Clyde B. Tenorio, Asst. Cook | Title VI Aging Program<br>P. O. Box 9<br>Santo Domingo, N. M. 87052<br>(505) 465-2214 Ext 34 |
| 38. Ray Tenorio, Tribal Council | Pueblo of Santo Domingo<br>P. O. Box 9<br>Santo Domingo, N. M. 87052<br>(505) 465-2214 Ext. 34 |
| 39. Martin Bird, Director | Title VI Aging Program<br>Pueblo of Santo Domingo<br>P. O. Box 9<br>Santo Domingo, N. M. 87052<br>(505)465-2214 Ext 34 |
| 40. Larry Curely, Exec. Director | Laguna Rainbow Corporation<br>P. O. Box 236<br>New Laguna, N. M. 87038<br>(505) 552-6035 |
| 41. Shelby Smith, Director | Title VI Program<br>Southern Ute Tribe<br>P. O. Box 296<br>Ignacio, Colo.<br>(303) 563-4517 |
| 42. Helena S. Pacheco | Interested Urban Indian<br>6220 Lomita PL. S. W.<br>Albuquerque, N. M. 87105 |
| 43. Mr. & Mrs. Jack Frost | Interested Indian Elderly<br>Southern Ute Tribe<br>Ignacio, Colo.<br>(303) 584-9238 or<br>563-4525 (Tribal Affairs Office) |
| 44. Rafalita C. Montoya | Retired & Interested Elderly<br>P. O. Box 462<br>Isleta, N. M. 87022<br>(505) 869-3680 |
| 45. Agnes H. Dill | Retired & Interested Elderly<br>P. O. Box 314<br>Isleta, N. M. 87022<br>(505) 869-6106 |

| | |
|---|---|
| 46. Dr. Walter Fisk | */American Indian Cultural Heritage Foundation<br>P. O. Box 1883<br>Albuquerque, N. M. 87103 |
| 47. Walter King Jr. Director | Title VI Program<br>Quapaw Tribe<br>P. O. Box 765<br>Quapaw, Oklahoma 74363<br>(918) 542-1853 |
| 48. Dee Ray Calabaza,Coordinator Aide | Title VI Program<br>Pueblo of Santo Domingo<br>P. O. Box 9<br>Santo Domingo, N. M. 87052<br>(505) 465-2214 Ext. 34 |

May 25,198

Edward R. Roybal, House Select Committee on Aging
Morris K. Udall, House Committee on the Interior and Insular Affair
Congressman William B. Richardson, New Mexico
Senator Jeff Bingaman, New Mexico

Dear Sirs,

Greetings to all, from the Tribe of Jemez. We the official representatives for the Tribe come to this special session with hopes of being recognized for our concerns regarding the ELDERLY of our Tribe.

We are most concerned with the type of provisions needed and lacking for our elderly population. Jemez Pueblo is a small Reservation located approximately 50 miles northwest of Albuquerque, New Mexico. The total population of enrolled Tribal members is 2,385. The total population among the elderly is 147, ranging from ages 60-90 years. The estimated income for the elderly averages approximately $250-$300 per month.

At the present time the elderly program include:

1. One meal a day provided four days a week. Funding for such is provided by Five Sandoval Indian Pueblos, Inc. This agency distributes the Federal Funds to the Five Pueblos.

The Elders who participate in the program in turn sustain their program by:

1. Fund raising activities, i.e., Bake sales, Bingo and Raffles.

The monies earned are in turn used for the maintenance and operation of a 1969 Van for transportation. The elderly also must pay for the services of a driver. Five Sandoval pays for the insurance on the Van.

The Elders of the Tribe have expressed on numerous occasions the need for the following items:

1. A Senior Citizen multipurpose building large enough to accomodate the total elderly population.
2. A Long Term Care facility, Skill/Custodial care (nursing home).
3. A bus/Van for safe,dependable transportation.
4. A Tribal member designated specifically for administrating the elderly programs/facilities.

We, the people of Jemez do not think that the NEEDS of the elderly population are being met adequately, especially, when one considers these to the total elderly population of the United States. We also think that YOU, the Senators and Congressmen, our voice and representatives in Washington D.C. are in a position to determine the Destiny for our people. With this in mind, We hope that you have heard our voices.

Respectfully Submitted,
The Tribe of Jemez
Trudie Narum, R.N., B.S.N., M.Ed.
Trudie Narum
Lydia Chinana, Community Services Coordinator
Lydia Chinana
Lupe Chosa, Elderly Program Representative
Lupe Chosa

# STATEMENT OF DANA R. NORRIS
# REGARDING TERMINATION OF SSI BENEFITS TO ELDERLY INDIANS RECEIVING BIA INSTITUTIONAL CARE FUNDS BEFORE THE HOUSE SELECT COMMITTEE ON ARGING

May 23, 1984
Tucson, Arizona

I am the elected Governor of the Gila River Indian Community and our Reservation is located generally south and east of Phoenix, Arizona. I am here today to state my concern with respect to long term care of our elderly Pima and Maricopa Indians.

We accord our Pima and Maricopa elders with much respect since not only are they the carriers and transmitters of our cultural heritage and traditions, but also because each has contributed to the continued survival of Pimas and Maricopas. Pimas and Maricopas, like all Tribes, have always attempted to provide the best possible resources for our elderly, especially health and social services.

We have one residential facility for long term care on the Gila River Indian Reservation and more such facilities are needed. Once the new hospital in Sacaton is completed, now scheduled for 1987, it may be advantageous to construct a long term care facility in Sacaton near the hospital. In any event, the Community and this Nation owes a debt to the elderly which must be paid and increased appropriation is only one avenue which may be traveled.

I now shall direct my remarks to a specific situation of immediate concern.

The elderly who need to live in an institution have had their funding reduced over the last two years by an informal rule of the Social Security Administration which seriously injures elderly Indian people.

If an elderly person is staying in a private nursing home under contract to a local or state funded program, they can get SSI benefits. This money is generally used to help pay for their care and for a small living allowance for personal expenses.

However, the Indian elderly are not treated as favorably. Because elderly Indians living on or near their reservation cannot get state assistance, they normally have their nursing home care provided through funds administered by the Bureau of Indian Affairs. Starting in late 1981 the Social Security Administration changed their rules and said that persons living in institutions receiving institutional care funding from the BIA would no longer be eligible for SSI. Not only did they stop pay benefits to the elderly, but they tried to collect overpayments from many nursing home residents for previous payments made by the Social Security Administration.

This rule change has caused serious harm for elderly Indian people. It has reduced greatly the total dollars available for institutional care. It has denied individuals the personal living allowance they would be entitled to if they were being funded by a state or county program. Finally, this new rule denies the elderly Indian that dignity and self worth which comes from contributing to one's own cost of care.

Several handicapped persons who have had their SSI benefits denied, reduced or terminated because of this new rule are currently challenging the rule in court. However, with appeals, this court action could take several years. Congress could easily solve the problem by requiring that BIA institutional care funds be treated the same as other in-kind income received by SSI recipients.

In many instances individuals challenging this new rule are being represented by attorneys funded by the Legal Services Corporation. Under new restrictive rules by the Legal Services Corporation, these attorneys are prohibited from contacting Congress, or assisting or suggesting that other contact Congress until after all judicial remedies have been exhausted. Attorneys representing eligible elderly clients should once again be allowed to bring their clients' problems to the attention of members of Congress and I request that this Committee express this concern to the appropriate committee which oversees the Legal Services Corporation.

Finally, I suggest that this Committee explore alternatives to institutionalization of the elderly. One alternative is foster family placement for certain elderly Indians supported with federal funds. Placement with a member of an extended family or other Indian family on the Gila River Indian Reservation should be explored.

I thank you for your attention to our concerns.

My name is J. Bart Graves. I am the Area Social Worker for the Bureau of Indian Affairs, Phoenix Area Office. I am representing James Stevens, Phoenix Area Director. I would like to provide a statement on the Phoenix Area Social Services program and its relationship to the 46 tribal governments served by the Phoenix Area. Indian Affairs social services consists of general assistance, child welfare assistance, emergency assistance and casework services. In this fiscal year '84, we will expend over $18 million dollars for social services to members of Phoenix Area tribes. A monthly average of 5,980 cases involving 11,124 persons receive these benefits.

Under the authority of PL 93-638, the Indian Self-Determination and Education Assistance Act, the social services program has been a high priority for Phoenix tribes for contracting. In FY 84, all but seven of the 46 tribes are receiving social services through 93-638 contracts. In the FY 84 national tribal budget planning priority setting process, the social services program was ranked No. 11 of 34 programs. In the Phoenix Area social services ranked No. 4. Based on this high degree of tribal involvement with human services programs, it is our assessment that Phoenix Area tribes would demonstrate a strong commitment to develop strategies and programs for care of the elderly Indians.

One important component of the social services program is Adult Institutional Care. This program is part of the welfare general assistance program. Adult Institutional Care provides supportive care to adult Indians in need of custodial and/or supervisory care due to emotional and physical conditions. This care is provided through a range of services, including purchase of supportive services for the individual in his own home; adult foster care; group living programs and nursing home care below the skilled care level.

To the extent feasible, our objective in the Phoenix Area is to have care for elderly available and provided within the Indians' home community. We have made some progress in meeting this objective. Ten years ago, all care was given in off-reservation facilities. This totalled about 300 persons principally in nursing homes. Today there are 120 placed off-reservation under Bureau payment. On-reservation care is now given to 100 Indian clients. Credit for this redirection must go to the tribal involvement in operating the social services program and directing as much care as possible to be given within the tribal community. Much improvement can be made, to the extent economically feasible, in making adult supportive care available within the tribal member's home community.

A problem was created for Indian elderly in 1983, when the Social Security Administration changed their interpretation of their SSI regulations to say that the payment made by the Bureau of Indian Affairs and the Indian Health Service for nursing home or residential care was actually income to the Indian person. The reason the Bureau supplements the residential cost of care of the SSI individual is adequate care is not available within the SSI payment amount. As the Bureau supplemental general assistance grant payments is not excluded as countable income, this resulted in from 300 to 400 elderly or severely disabled Indian persons in this area losing their eligibility for their Supplemental Security Income (SSI) check.

To an elderly person, the loss of an SSI check can be devastating. For Arizona residents, receipt of SSI makes one categorically eligible under the State's ACCHESS (health care) program. When the SSI check stops, the person must re-apply for ACCHESS as an individual applicant. Elderly Indian persons in residential care, quite often do not have the strength or stamina to pursue this application.

Psychologically, the loss of SSI can be worrisome to elderly persons who, even though the SSI check was endorsed almost upon reciept to pay for their care, felt better about themselves knowing that they received their own check.

A further hardship was created for the elderly Indian person who left the nursing home facility to return home and had to re-apply for SSI benefits; a time-consuming and complicated process.

We believe that the Bureau of Indian Affairs payment for out-of-home and nursing home care for eligible Indians, is a supplementary payment which augments the Indian person's own funds/resources such as SSI benefits, and is not intended to replace the Indian person's eligibility for SSI.

We also question how the BIA payment to a nursing home could ever be considered as income to the elderly Indian, as this is a direct payment from the government to the nursing home for reimbursement for care provided and the individual Indian is not involved in the receipt of a check.

One result of the change in policy interpretation by the Social Security Administration is that more grant assistance funds of the Bureau of Indian Affairs are now being spent for nursing home care and less funds are available for other social services program needs which have been identified by the Indian communities.

In summary, there should be a continuum of services available for elderly Indians to help meet their needs as they become older and often less independent. Good health care, meals programs, adequate housing and transportation assistance are all essential. For those who can no longer live at home, a variety of resources should be available which provide alternatives to institutional care. And for those who do need more care, closer to home facilities are needed which enable the person to openly and freely maintain ties with their friends, family and culture.

STATEMENT

BY

DR. CRAIG VANDERWAGON

FOR THE

INDIAN HEALTH SERVICE

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE INTERIOR AND INSULAR AFFAIRS COMMITTEE

AND

HOUSE SELECT COMMITTEE ON AGING

AT

TUCSON, ARIZONA

MAY 25, 1984

Mr. Chairman and Members of the Committee: I am Dr. Craig Vanderwagen, Office of Program Operations, Indian Health Service.

I am pleased to be here today to discuss the programs of the Indian Health Service (IHS), particularly with regard to the Indian elderly.

As you are aware, the Indian Health Service provides a comprehensive program encompassing preventive, acute, and chronic care services to American Indians and Alaska Natives of all ages. The hallmark of the IHS program has been a balanced set of services designed to meet the epidemiologically defined needs of our Service population.

The success of this balanced, epidemiologically defined set of services is attested to by the increasing life expectancy at birth of American Indians and Alaska Natives. A recent report prepared by the IHS staff analyzed the life expectancy at birth of our Service population for the period 1969-71 and compared these statistics to similar data from the period 1979-81. This study revealed that in the 10 year period described, the average life expectancy at birth for American Indians and Alaska Natives of both sexes increased an average of 6.0 years. The members of our Service population may expect to live to an age of greater than 70 years. While this is still below the figures for the U. S. population of all races, who may expect to live to 73.7 years, it does reveal that an aging population is developing in Indian country.

Currently the population over age 65 constitutes 5.2% of the IHS service population. In absolute numbers, this means that 47,700 individuals of the 930,000 IHS service population are over age 65. Of this elderly group, approximately 22,000 are eligible for Medicare Part A, and 12,000 are eligible for both Parts A and B. Under provisions of P.L.94-437, the IHS is allowed to bill Medicare for services provided to eligible Indian patients. The funds recovered under these provisions are by law to be used to redress Joint Commission on Accreditation of Hospitals deficiencies. In FY 83 the IHS collected $14,681,000 under Medicare.

The provision of health services to this population requires many resources. In FY 1983, the number of visits to IHS ambulatory facilities by patients older than age 65 accounted for 10% of all visits. The number of inpatient hospital days accounted for by this group totaled greater than 15% of hospital days for patient care in IHS hospitals. An analysis of resource intensiveness reveals that services provided to those over 65 years were more resource intensive than for younger patients. If national trends in this population may be extrapolated to our service population, the use of IHS acute services by the elderly will increase resulting in an ever greater proportional use of IHS resources.

The Indian Health Service recognizes these trends and has developed a number of programmatic approaches to address the issues of health care for the elderly.

In the area of preventive programs, IHS has, either through its directly operated facilities or in conjunction with tribal health programs, initiated many activities. In its directly operated programs specific curricula have been developed in nutrition, health education, environmental issues, and disease-related areas (such as diabetes) to increase health maintenance behaviors in elderly populations. This is typified by the Central Diabetes Program in the IHS. This program, which utilizes a multi-disciplinary team, has been operational for three years. The program emphasis has targeted the prevention of such catastrophic sequelae of Type II diabetes as amputations and end-stage renal disease. Through the collaborative efforts of IHS providers, tribal-community groups, and the National Diabetes Advisory Board, a program was developed to prevent the above problems which incapacitate many, primarily older, Indian patients.

IHS-funded tribal health activities also reveal many efforts in this area. Tribally operated Community Health Representative programs have had as a main emphasis, health promotion among elderly populations. This is a well defined element of the scopes of work negotiated with the Tribes for Community Health Representatives.

Acute care for the elderly is a vital, ongoing element of the IHS program. As the statistics presented earlier suggest, the elderly receive care in expected frequencies. The acute care programs encompass a full range of ambulatory and inpatient care.

Chronic care programs utilize ambulatory, inpatient, and community services. These programs involve a variety of providers including physicians, nursing personnel, both in facilities and communities, nutritionists, dentists, physical therapists and many others. These programs reflect the efforts of IHS and tribal employees. Our efforts in providing chronic care to the elderly and others is typified by programs involving the collaborative efforts of IHS providers and tribally operated home health care agencies. In these activities, IHS providers work together with tribal employees to effectively develop discharge and home care plans for elderly individuals discharged from inpatient care but requiring continued care in the home. The continued monitoring of the patient's health status by this team is paramount to early diagnosis and intervention or prevention. This approach has proved successful in many locations over time. The Zuni Tribal Home Health Care Agency has, for example, been quite successful over the last three years in working closely with the staff of the IHS Zuni Comprehensive Health Center.

These examples serve to demonstrate how the IHS has developed programs appropriate to the needs of an aging Indian population. Further refinement of the approaches to these issues is ongoing. The IHS is part of the Indian Elders Initiative Task Group sponsored by the Office of the Assistant Secretary for Human Development Services. This Task Group, which has representation from the Administration on Aging, the Administration for Native Americans, the Indian Health Service and other elements of the Department of Health and Human Services, is working steadily to enhance and coordinate policy development in Indian elderly health care issues.

I hope that this illustrative, rather than exhaustive, presentation of information aids the Committee in its understanding of the Indian Health Service approach to health care for elderly American Indians and Alaska Natives.

I will be most happy to answer any questions that you may have at this time.

CVANDERWAGEN:jdavis 5/16/84 1512C - Revised 5/18/84

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

JOHN O'HARA

ASSOCIATE REGIONAL ADMINISTRATOR FOR PROGRAM OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

REGION IX

BEFORE THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS

AND

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

MAY 25, 1984

I am John O'Hara, Associate Regional Administrator for Program Operations for Region IX of the Health Care Financing Administration. I am pleased to be here today to represent my agency in your deliberations concerning long term care and Native Americans. In my statement I will describe the Medicare and Medicaid programs and the roles they play in financing long term health care for the Indian people.

## Medicare

Medicare is designed to provide primarily acute care services, which consume about 95 percent of program expenditures annually. However, a limited amount of care is provided under Medicare in what are traditionally considered long term care settings, such as skilled nursing faciltities (SNFs), home health agencies and hospices. Beneficiaries who require skilled care can receive it on a daily basis as an inpatient in a SNF on a time-limited basis or at home on a part-time or intermittent basis from home health agencies. Terminally ill Medicare patients also can now elect to receive hospice care in lieu of regular Medicare coverage.

Today, over 26 million aged and another 3 million disabled persons are covered under Medicare. Prior to Medicare many of these people did not have access to adequate health care. For much of this population Medicare has assured that they need not fear the burden of high hospital or physician bills.

To become eligible for Medicare, an individual must be at least age 65 or be determined by Social Security to be disabled, and must have worked for a certain period of time at a job that was covered under the Social Security retirement system.

In discussing the eligibility of the Indian population for Medicare, it is useful to distinguish between those who live on the reservation and are part of the service population of the Indian Health Service (IHS), and those who have moved into the broader community. Of the IHS service population of 909,000, about 47,000 are age 65 or over. Of this group, it is estimated that less than half are eligible for Medicare because of limited earnings records and other factors. It is expected that this percentage will improve in future years. That part of the Indian population which is not part of the IHS service area amounts to about 630,000, including about 33,100 age 65 or over. Although data are limited, this group is estimated to have Medicare eligibility levels closer to the general population.

## Medicaid

The Medicaid program, which is administered by the States within broad Federal guidelines, traditionally has had an emphasis on meeting the long term care needs of the poor. Over half of the annual program exeenditures are for long term care services.

MEDICAID COVERS CARE PROVIDED BY A SNF OR AN INTERMEDIATE CARE FACILITY (ICF), AS WELL AS CARE PROVIDED THROUGH HOME HEALTH AGENCIES AND BY OTHER INDIVIDUAL PRACTITIONERS (SUCH AS A NURSE) WHO GO TO A PATIENT'S HOME. HOWEVER, IN ARIZONA, THE LONG TERM CARE NEEDS OF THE INDIGENT POPULATION CONTINUE TO BE MET THROUGH COUNTY RESOURCES.

IN ADDITION, MEDICAID, UNLIKE MEDICARE, ALLOWS STATES TO COVER THE PROVISION OF CERTAIN PERSONAL CARE SERVICES UNDER THE HOME AND COMMUNITY-BASED WAIVER PROGRAM. STATES MAY SEEK WAIVERS OF CERTAIN MEDICAID REGULATIONS TO ESTABLISH PROGRAMS OF HOME AND COMMUNITY-BASED CARE TARGETED AT GROUPS OF INDIVIDUALS WHO ARE AT RISK OF INSTITUTIONALIZATION.

THE MEDICAID PROGRAM IS DESIGNED TO PROVIDE HEALTH CARE FOR CERTAIN GROUPS OF LOW-INCOME PEOPLE, PRIMARILY THOSE ALREADY RECEIVING CASH ASSISTANCE. THIS GENERALLY INCLUDES MEMBERS OF FAMILIES WITH DEPENDENT CHILDREN AND THE AGED, BLIND AND DISABLED. IN ADDITION, STATES MAY CHOOSE TO PAY FOR THE CARE OF THOSE INDIVIDUALS WHO ARE "MEDICALLY NEEDY"--THAT IS, FAMILIES WHO HAVE ENOUGH INCOME TO PAY FOR THEIR BASIC LIVING EXPENSES, BUT NOT ENOUGH TO PAY FOR THEIR MEDICAL CARE. CURRENTLY, 20 STATES AND TERRITORIES COVER ONLY THOSE INDIVIDUALS RECEIVING CASH ASSISTANCE, AND 34 STATES AND TERRITORIES COVER BOTH CASH ASSISTANCE AND MEDICALLY NEEDY RECIPIENTS. IT IS THESE GENERAL ELIGIBILITY CONDITIONS THAT INDIANS, AS OTHERS, MUST MEET IN ORDER TO QUALIFY FOR MEDICAID.

With the exception of care for the Indians, the cost for Medicaid services are shared by the Federal and State governments. The Federal government fully funds States for all Medicaid services provided to Indians in IHS facilities.

## Indians and the Medicare/Medicaid Programs

Recognizing that Indians who live on reservations do not always have access to participating Medicare and Medicaid facilities, Congress enacted provisions in the Indian Health Care Improvement Act of 1976 (P.L. 94-437) to pay IHS for Medicare and Medicaid services provided in IHS facilities to Indians eligible for these programs. The law requires that these payments be used to upgrade and maintain the quality of IHS medical facilities so that they meet Medicare and Medicaid standards, which has happened. To date, over $80 million has been paid to the IHS for Medicare and Mediaid services provided to Indians.

Under Medicare, the IHS may receive payment for services provided to beneficiaries in hospitals or skilled nursing facilities operated by the IHS or a recognized tribal organization. Under Medicaid, the IHS may receive payment for services provided to Medicaid recipients in hospitals, SNFs and ICFs. The IHS facilities must meet all Medicare and Medicaid health and safety standards in order to receive payment by either program.

However, because the IHS health care system is geared to meeting preventive, acute care and ambulatory care needs, it does not operate any SNFs or ICFs as such. Its focus has been on working closely with the Bureau of Indian Affairs in developing community-based programs which can provide coordinated health and social services for the elderly. The IHS does assist the patients in gaining access to appropriate long term care facilities outside the IHS system.

As you can see, both Medicare and Medicaid payments are available for services provided to Indians by IHS facilities or by facilities operated by recognized tribal organizations. For those Indian people living off the reservation who are not part of the IHS service population, Medicare and Medicaid payments are available to their local health care providers to the same extent as to other eligible citizens.

There are a few demographic and other factors which limit to some extent the amount of these services that are provided. Currently, only about 5.2 percent of the Indian population is age 65 or over, contrasted with over 11 percent of the total U.S. population. Recent increases in life expectancy are expected to raise this percentage substantially over the next few decades.

ANOTHER POSSIBLE LIMITING FACTOR IS THE WIDESPREAD DISPERSION OF THIS GROUP OF ELDERLY PEOPLE. CONCENTRATIONS OF ELDERLY ARE NOT AVAILABLE IN A WAY THAT WOULD LEND THEMSELVES TO ECONOMICAL INSTITUTIONAL SETTINGS SUCH AS NURSING HOMES. THIS, IN PART, CONTRIBUTES TO THE NEED TO FOCUS ON COMMUNITY-BASED CARE AND HOME CARE.

## CONCLUSION

WE UNDERSTAND ONLY TOO WELL THE CHALLENGES THAT MUST BE MET TO ASSURE THAT ALL OUR CITIZENS HAVE ADEQUATE ACCESS OF NECESSARY CARE AND SERVICES. MEETING THE LONG-TERM CARE NEEDS OF THE INDIAN POPULATION PRESENT PARTICULAR PROBLEMS, AND WE HAVE BEEN WORKING TO SEE THAT WE DO OUR PART IN MEETING THESE NEEDS. MY AGENCY STANDS READY TO COORDINATE MEDICARE AND MEDICAID RESOURCES WITH OTHER PUBLIC AND PRIVATE RESOURCES TO ASSURE THAT THE NEEDS OF INDIANS ARE MET IN THE BEST WAY POSSIBLE.

STATEMENT BY
JOHN MCCARTHY
REGIONAL PROGRAM DIRECTOR
REGION IX
ADMINISTRATION ON AGING

A JOINT HEARING OF
THE SELECT COMMITTEE ON AGING
AND THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
HOUSE OF REPRESENTATIVES

TUCSON, ARIZONA
MAY 25, 1984.

Mr. Chairman and members of the Select Committee on Aging and the Committee on the Interior and Insular Affairs, I am pleased to appear before you today to explore the impact of long term care issues on health and social services for older Indians. The Administration on Aging has a long standing interest and commitment to long term care systems for the vulnerable elderly, in particular, those long term care systems that are community based.

The Older Americans Act was enacted in 1965. Title II of the Older Americans Act establishes the Administration on Aging (AoA) as the principal Federal agency for carrying out the provisions of the Act. These provisions also require AoA to coordinate and assist in the planning and development of programs for older individuals by public and private organizations with a view to establishment of a nationwide network of comprehensive, coordinated services and opportunities for such individuals. This title also describes the basic roles and functions of AoA. Important among these are to administer the programs authorized by Congress under Titles III, IV, and VI of the Act, and to serve as an effective and visible advocate for older persons within the Department and with other agencies and organizations.

This mandate to develop community based services has implications with respect to long term care. We, at the Administration on Aging, view a long term care system as much broader than institutions such as hospitals or nursing homes. As you know, during the middle portion of this century, American social policy somewhat inadvertently created a reliance on institutions as a major mechanism for providing long term care. The phrase "long term care" became associated primarily with health care provided in hospitals and other medical facilities such as nursing homes, extended care facilities and rehabilitation centers.

Beginning in the late 1960's, however, efforts to create alternative approaches to that reliance on institutions gathered force. The programs of the Administration on Aging have been an element in this reform. In recent years, it has become increasingly clear that long term care should not be exclusively medical or institutional. Rather, it is now generally recognized that long term care has supportive services dimensions, and that for most persons it can be provided in a variety of noninstitutional settings including an individual's own home as well as supervised community residences, family-style boarding homes, and foster care homes for adults.

The Administration on Aging is currently involved in two major efforts to expand the base of knowledge about long term care and to facilitate development of community-based programs, namely, the Channeling Demonstration Program (in partnership with the Health Care Financing Administration) and the Long Term Care Gerontology Centers Program. I shall discuss this more in detail later but first I want to share with you the kinds of activities the Administration on Aging is supporting thorugh Titles III and VI of the Older Americans Act.

I would like to begin with a brief history of the Title VI program and a description of its current status. As most of you know, Title VI was enacted into law as a result of the 1978 Amendments to the Older Americans Act. Earlier legislation had given priority to elderly minorities and low income seniors. However, there was a general consensus on the part of Indian organizations, Tribes and national aging organizations that older Indians were not receiving equitable services under the Act. Although many Indian elders benefitted from OAA services, in general they remained largely an underserved population. In addition, where the Indian older persons were being provided services under Title III, often this was accomplished in ignorance of essential cultural values which further alienated the Indian older persons from participating in the program. As a result, concerned Indian Tribes, organizations and individuals began to advocate for a mechanism of direct funding to Indian Tribes. This effort was formalized at the 1971 White House Conference on Aging by presenting specific recommendations to address the needs of Indian elders.

In 1978, Congress amended the Act to include Title VI which provided for direct award of grants to Indian Tribes. Title VI provides for nutrition and supportive services comparable to those provided under Title III. However, neither the title nor the regulations are as restrictive as Title III with the result that Tribes have great flexibility in developing programs that are based on traditional cultural values and reflect local needs and strengths.

In the first year of operation, with a Congressional appropriation of $6 million for Title VI, eighty-five tribal organizations were funded. In the second year (FY 1981), eighty-four Tribes were funded. During that year, 1981, Congress enacted several provisions in the Act which allowed additional flexibility to tribal organizations in administering their programs, such as dropping a specific age criteria for service eligibility. In FY 1982, and 1983, 83 tribal organizations were funded with an appropriation of $5,735,000. We are currently accepting applications for FY 1984. The President has asked Congress to increase the appropriation for

Title VI in 1985 to $7,500,000 but the actual amount for funding will not be known until an appropriation is signed into law. AoA anticipates funding 20 to 25 new projects in amounts ranging from $50,000 to $100,000, contingent upon final appropriation of the amount requested in the FY 1985 budget.

What services are being provided under Title VI? In a national evaluation compiled in October 1983 by the Native American Consultants, Inc. (NACI), it was found that all grantees provided nutrition and information and referral services. Meals were usually provided five days a week, although some projects chose to do so less frequently in order to encompass a larger geographic area. Home-delivered meals have made Title VI services accessible to Indian elders who would otherwise be excluded due to poor health, responsibility for the care of grandchildren or lack of transportation. Congregate meals have also increased the social contacts of the participants thus reducing isolation and loneliness.

Since the 1981 Amendments to the Act, Tribes have devoted sixty-five percent of the Title VI funds to congregate and home-delivered meals. The Title VI service reports for the year ending September 30, 1982 showed 1 million congregate meals from all funding sources were provided to 12 thousand home-delivered meals to about 5 thousand older Indians and their spouses. In addition, a total of about ¶3 thousand persons received supportive services.

A variety of optional supportive services were provided under Title VI, transportation being one of the most frequently provided service. A few programs provide in-home services, such as wood chopping, hauling of water, and/or fuel and other chores. Some tribal organizations provide ombudsman services. However, NACI specifically cited long term care services as a major gap in essential services for the Indian elderly. I shall present later a few initiatives undertaken by the Administration on Aging to address the need when I discuss the Title IV program. Before I do this, however, I would like to talk briefly about the Title III program.

Many of you are familiar with the network of State and area agencies under Title III of the Act. The broad objectives of the Act and their specific provisions are implemented primarily through a national "Network on Aging" consisting of the Administration on Aging at the Federal level, State and Area Agencies on Aging, Indian Tribes, and the extended Network which includes the agencies and organizations providing direct services at the community level to older individuals.

Under Title III, the Administration on Aging annually awards grants to the States to foster the development of comprehensive and coordinated service systems to serve older individuals, to:

"...(1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services;

(2) Remove individual and social barriers to economic and personal independence for older individuals; and

(3) Provide a continuum of care for the vulnerable elderly."

Fifty-seven State and Territorial agencies receive support under Title III of the Act. These agencies are organizationally located in State Governments, Territories, and other U.S. Jurisdictions, either as independent agencies reporting directly to the Governor, or as components of larger human service agencies.

States have designated approximately 662 Area Agencies on Aging to plan and adminster Title III programs. An Area Agency on Aging may be a public or private organization, an Indian Tribe, or a Sub-State Regional body. Area agencies have the major responsibility for the administration of funds for Title III-B supportive services and Title III-C nutrition services. Area agencies are responsible for providing technical assistance to, and monitoring the effectiveness and efficiency of, their respective service providers. Seven Indian Tribes are Area Agencies on Aging.

The reports from the State and area agencies for Title III for the year ending September 30, 1983 showed an estimated number of 9 million persons receiving supportive services of whom 40 thousand were American Indians or Alaskan Natives. There were 145 million congregate meals served, from all funding sources, to 3 million persons, of whom 38 thousand were American Indians or Alaskan Natives. In home-delivered meals, there were 58 million meals to 589 thousand persons, of whom 7 thousand were American Indians or Alaskan Natives. The Indians served under Title III are in addition to those served under Title VI,

We are encouraging State and area agencies to serve more minorities through our national minority initiative, under which the National Indian Council on Aging (NICOA) is participating in a series of Bi-Regional workshops with State and area agency staff to identify ways of increasing minority participation in Title III programs.

AoA's concern about the needs of older Indians is reflected in its research, demonstration, and Center programs under Title IV of the Act. As its major discretionary program effort to address the long term care needs of the elderly, AoA is currently funding eleven multidisciplinary Long Term Care Gerontoloy Centers across the country.

These Centers are designed to build a knowledge base and to disseminate information about long term care. The Centers provide interdisciplinary geriatric/gerontological training of professionals in the fields of health, nursing, social work and other related professionals. The Centers also are responsible for developing service models, conducting research and providing assistance to service providers.

Three of the Long Term Care Gerontology Centers are conducting special activities relating to the needs and concerns of older Indians. The University of Arizona Center in Tucson has assumed a major role in serving as a national resource for the long term care needs of older Native Americans. The Arizona Center has assumed this role because of the Center's unique location in the Southwest which has a high concentration of Native Americans. The Arizona Center functions as a national resource for gathering, interpreting, analyzing and disseminating information.

The Arizona Center has engaged in a number of activities with several Indian Tribes. They have studied aging services and policy development in the Navajo Nation and the effects of relocation on elderly Navajos. The Navajos have traditionally had a strong tribal commitment to provide aging services; however, the study by the Arizona Center recommended that the Navajo Nation establish a process for providing a continuum of care for elder Indians.

The Arizona Center has completed another study entitled a Profile of Indian Nursing Homes. This study provides a profile of eight nursing care facilities located on reservation land. Four of these facilities are in Arizona and serve the Papago, Pima, Navajo and Apache Tribes. One facility is located on the Blackfeet reservation in Montana, one on the Laguna reservation in New Mexico, one on the Omaha reservation in Nebraska and the eighth one is in Wisconsin on the Oneida reservation. The study identifies a number of areas for future exploration of the best approaches for providing long term care in Indian communities.

Recently, the Center completed a study for the Papago Tribe regarding the feasibility of constructing a 50-bed nursing home on the Papago Reservation. The Center provided consultation and recommendations to the Tribe for alternative approaches for meeting long term care needs.

The Center has also conducted several short-term training courses for Indian service providers. Also, the Pascua Yaqui Indian Tribe contracted with the Center for the conduct of the evaulation of the Tribe's Title VI evaluation in 1982.

The Long Term Care Gerontology Center at the University of Utah is involved with the Navajo community in Southern Utah. They conducted a needs assessment and identified resources available to meet those needs. The Center is providing technical assistance to the Senior Center for further development of its program. A workshop for elderly caregivers and aging service providers for improving service delivery systems is planned in June. Through assistance provided to the Navajos by the Utah Center, community leaders in some of the small towns have banded together to form an association for coordinating efforts. The Utah Center is providing materials to form a gerontological library at the medical clinic and at the two schools which serve the area.

The University of Washington Long Term Care Gerontology Center received an award for $11,000 from the Indian Health Service to develop a geriatric health care model for health paraprofessionals who work in tribal settings. A three day symposium is planned for late May for community health representatives from around the country. This session will focus on gerontological training and will result in the development a model training program for paraprofessionals in rural areas.

Also, the Washington Center is working with the Older Alaskan Commission to design a data base analysis and tracking system. With the establishment of the new data system, the Alaska Commission expects to improve the delivery of relevant services throughout the State which will ultimately result in improved services to Alaskan Native Americans.

During the past several years, the Administration on Aging (AoA) has funded several other discretionary grant projects related to Indian concerns. In 1976, AoA provided funds for the first national Indian conference on aging. A major report prepared by Juana Lyon entitled Indian Elder, A Forgotten American was a product of that conference. Since that time AoA has provided continuing financial support to the National Indian Council on Aging (NICOA) to undertake a number of initiatives. These initiatives include an ongoing needs analysis, resoucre development and the development of service programs for older Indians.

AoA has funded three other projects involving Indian Tribes under Title IV. These projects included improvement of the farming business at the Tule River Tribe in Porterville, California; development of employment opportunities for older Indians at the Ketchikan Indian Corporation in Alaska; and improvement of health services at the Confederated Tribes of Chehalis, Oakville, Washington. A contract for the evaluation of the Title VI program was awarded to the Native American Consultants, Inc. This report was completed in October, 1983.

In closing, I would like to point out a few facts unique to Indian communities which must be considered in developing long term care services for older Indians. These factors include the geographic distribution of population, the availability of informal caregivers, the number and location of institutional facilities, and the unique cultural needs of older Indians.

The elderly Indian population is generally dispersed throughout vast geographic and usually very rural areas. Consequently, it is expensive to provide needed services to the elderly Indians. As in the case of other groups, the role of the middle-aged Indian woman caregiver is diminishing. Many middle-aged women now work and are unable to provide traditional care for their elders. Current financing systems for meeting the cost of long term care tend to favor placement of the Indian elderly persons in a long term care facility which is financially expensive and often less than satisfactory because of institutional inability to attend to cultural needs.

I want to thank you for this opportunity to share with you some of the activities and experiences we at the Administration on Aging have had in the programs funded under the Older Americans Act. I would be glad to answer any questions you have.

Statement by

Larry Curley, Executive Director
Laguna Rainbow Corporation

on

May 25, 1984

before

a

Joint Hearing of

the House Select Committee on Aging

and the

Committee on Interior and Insular Affairs

GOOD AFTERNOON, MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE PANEL. MY NAME IS LARRY CURLEY AND I AM CURRENTLY THE EXECUTIVE DIRECTOR OF THE LAGUNA RAINBOW CORPORATION FOR THE PUEBLO OF LAGUNA IN LAGUNA, NEW MEXICO.

THE LAGUNA RAINBOW CORPORATION IS AN UMBRELLA ORGANIZATION ESTABLISHED BY THE TRIBAL COUNCIL OF THE PUEBLO OF LAGUNA IN 1979 TO PROVIDE AN ARRAY OF PROGRAMS AND SERVICES TO THE ELDERLY OF THE PUEBLO. CURRENTLY, THE CORPORATION IS PROVIDING A RANGE OF SERVICES FROM HOME-DELIVERED MEALS TO OPERATING AN INTERMEDIATE CARE FACILITY. PHILOSOPHICALLY, THE CORPORATION HAS ENDEVORED TO DEVELOP A COMPREHENSIVE SERVICE DELIVERY SYSTEM THAT IS DESIGNED TO PREVENT PREMATURE OR INAPPROPRIATE INSTITUTIONALIZAITON. IN THE COURSE OF DEVELOPING THIS SYSTEM, WE HAVE ENCOUNTERED A VARIETY OF ISSUES THAT WE BELIEVE NEED TO BE ADDRESSED, NOT ONLY LOCALLY, BUT NATIONWIDE.

HISTORICALLY, IT SEEMS THAT THE INDIAN COMMUNITY IS ABOUT TEN TO FIFTEEN YEARS BEHIND ITS NON-INDIAN COUNTERPART. EVENTS AND TRENDS DEVELOPED IN THIS COUNTRY MANIFEST THEMSELVES IN THE INDIAN COMMUNITY APPROXIMATELY TEN TO FIFTEEN YEARS LATER. SO IT HAS BEEN WITH THE DEVELOPMENT OF PROGRAMS FOR THE ELDERLY INDIAN. IN THE PAST, THE ELDERLY OF OUR INDIAN COMMUNITIES WERE CARED FOR IN THE HOME, BY THEIR FAMILIES. WITH THE TIMES, THESE ARRANGEMENTS ARE RAPIDLY DISAPPEARING AND WE ARE ENCOUNTERING THE NEED TO RESPOND TO THESE PROBLEMS. IN SOME AREAS OF THE COUNTRY, THE PROBLEMS ARE AT A CRISIS STAGE, WHILE IN OTHERS, IT WILL BE SOON. SO WE NOW FIND THAT THERE IS A NEED FOR NURSING HOMES AND OTHER PROGRAMS TO BENEFIT OUR ELDERLY.

IN 1970, THERE WERE ONLY 64,000 ELDERLY INDIANS IN THE UNITED STATES. IN 1980, THERE WERE APPROXIMATELY 109,000 ELDERLY INDIANS -- AN INCREASE OF ABOUT 71%! BY 1990, IT IS VERY LIKELY THAT THIS POPULATION WILL DOUBLE. IT IS WITH THIS IN MIND THAT WE ARE HERE TODAY. IT HAS BEEN ESTIMATED THAT IN ANY GIVEN POPULATION OF ELDERLY PEOPLE, 5% ARE GOING TO BE IN INSTITUTIONS. IF THAT HOLDS TRUE FOR THE INDIAN COMMUNITY, THEN THERE ARE 5,450 INSTITUTIONALIZED SOMEHWERE AT THIS VERY MOMENT. WITH ONLY NINE LONG TERM CARE FACILITIES ON INDIAN RESERVATIONS TODAY, WITH A TOTAL BED CAPACITY OF LESS THAN 500 -- WHERE ARE THEY?

MORE THAN LIKELY, THEY ARE IN A FOREIGN, NON-INDIAN FACILITY WITH A LIKELIHOOD THAT THEY WILL NOT SEE ANOTHER CHRISTMAS. OBVIOUSLY, THIS IS A NEED THAT BEGS TO BE ADDRESSED. AS ONE BEGINS TO ADDRESS THESE NEEDS BY BEGINNING TO BUILD THE INFRASTRUCTURES, REALIZE THAT THERE ARE ONLY THREE INDIANS NATIONWIDE THAT HAVE BEEN TRAINED TO ADMINISTER AND MANAGE LONG TERM CARE FACILITIES. I AM ONE OF THOSE THREE. THE SHORTAGE IS CRITICAL.

BUILDING LONG TERM CARE FACILITIES IS NOT THE ONLY ANSWER. AS WE ALL KNOW OR ARE BEGINNING TO KNOW, THE PROVISION OF THIS LEVEL OF CARE IS THE MOST EXPENSIVE AND INTENSIVE FORM OF SERVICE. IN ADDITION, IT IS THE LEAST FAVORED BY OUR ELDERLY . . . I BELIEVE THESE SENTIMENTS ARE ALSO SHARED BY NON-INDIAN ELDERS, AS WELL.

WE NEED TO BEGIN TO DEVELOP COMPREHENSIVE SERVICE DELIVERY SYSTEMS THAT ARE FLUID AND ACCOMODATING OF THE CHANGES IN OUR COMMUNITIES. WE CANNOT DO THAT WHEN OUR COMMUNITIES AND OUR ELDERS HAVE TO COMPETE WITH

THE MX, THE B-1 AND THE TRIDENT. THERE ARE A VARIETY OF PROGRAMS THAT HAVE THE POTENTIAL OF DEVELOPING THESE SYSTEMS.

IN A STUDY COMPLETED BY THE NATIONAL INDIAN COUNCIL ON AGING IN 1981, IT WAS FOUND THAT INDIAN PEOPLE AT AGE 45 BEGIN TO EXHIBIT FUNCTIONAL DISABILITIES THAT NON-INDIANS DO AT AGE 65. INDIAN PEOPLE, PHYSICALLY, ARE "OLD" AT AGE 45. THE REASONS FOR THIS IS THAT MOST OF THE CHRONIC PROBLEMS THAT FOLLOWED THEM THROUGH LIFE AT AGE 45 BECOME DEBILITATING. OVER 50% OF OUR ELDERLY ARE BELOW THE LOW INCOME LEVEL AND IN 25% OF THE HOUSEHOLDS, GRANDPARENTS TOOK CARE OF AT LEAST ONE GRANDCHILD. THE LIFE EXPECTANCY OF INDIAN PEOPLE IS ALMOST 10 YEARS LESS THAN THE GENERAL POPULATION . . . AND IT IS WORTHWHILE TO NOTE THAT IN A FEW YEARS, ELIGIBIITY FOR SOCIAL SECURITY BENEFITS WILL BEGIN AT AGE 68, RATHER THAN 65. THIS, IN EFFECT WILL MEAN LESS INDIANS IN THE SOCIAL SECURITY SYSTEM.

WITH ALL THE PRECEDING AS BACKGROUND AND AS A POINT OF DISCUSSION WE BELIEVE THAT IN ORDER TO BEGIN TO MEET THE NEEDS OF OUR ELDERLY INDIANS, CONGRESS NEEDS FIRST, TO BE AWARE OF THE PROBLEM AND SECONDLY, TO BEGIN TO ADDRESS THESE ISSUES. WE RECOMMEND THAT THE FOLLOWING BE ISSUES THAT CONGRESS NEEDS TO REVIEW:

1. MEDICAID AND MEDICARE FUNDS SHOULD BE CONTRACTED DIRECTLY WITH INDIAN TRIBES

   WE BELIEVE THAT THIS WOULD STRENGTHEN AND REAFIRM THE FEDERAL TRUST RELATIONSHIP BETWEN THE TRIBES AND THE FEDERAL GOVERNMENT. IN ADDITION, IT WOULD ENABLE TRIBES TO ESTABLISH THEIR OWN

STANDARDS AND DEFINITIONS REGARDING SERVICES. IT WOULD ALSO ALLOW THEM TO DEVELOP MORE REALISTIC REIMBURSEMENT RATES FOR LONG TERM CARE FACILITIES. IT IS POSSIBLE THAT THESE FUNDS CAN BE CHANNELLED THROUGH THE INDIAN HEALTH SERVICE AND HAVE AREA OFFICES ACT AS THE "STATE AGENCY." THIS WOULD BE EXTREMELY HELPFUL TO THOSE INDIAN TRIBES RESIDING IN STATES WHICH DO NOT PARTICIPATE IN THE MEDICAID PROGRAM.

2. THAT INDIAN TRIBES BE ABLE TO CONTRACT DIRECTLY WITH THE FEDERAL GOVERNMENT FOR TITLE XX, SOCIAL SERVICE BLOCK GRANTS

CONGRESS RECENTLY PASSED LEGISLATION TO ALLOW TRIBES TO RECEIVE DIRECT GRANTS FOR CERTAIN PROGRAMS UNDER THE TITLE XX PROGRAM. HOWEVER, THE SOCIAL SERVICES ASPECT OF THE PROGRAM WAS NOT IDENTIFIED AS ONE ELIGIBLE FOR THIS MECHANISM. THE ALLOCATION OF FUNDS, WE BELIEVE, SHOULD NOT BE ON A PER CAPITA BASIS, BUT RATHER ON MINIMUM FUNDING LEVELS AND ADDITIONAL FUNDING BASED ON POPULATION. THIS WILL ALLOW INDIAN TRIBES TO DEVELOP PROGRAMS THAT WILL ENABLE THEIR ELDERLY TO REMAIN AT HOME AND THEREBY DELAY INSTITUTIONALIZATION. IT WILL BE CHEAPER AND MORE COST EFFECTIVE THAN INSTITUTIONAL CARE.

3. THAT CONGRESS DEVELOP AND PASS AN "INDIAN ELDERLY WELFARE ACT"

DUE TO THE LARGE NUMBER OF ELDERLY INDIANS RESIDING IN OFF-RESERVATION LONG TERM CARE FACILITIES, THE JURISDICTION OF THE TRIBAL GOVERNMENT NEEDS TO BE EXTENDED TO THESE INDIVIDUALS TO ENSURE THAT THEIR "NURSING HOME BILL OF RIGHTS" IS PROTECTED. THIS ACT WOULD BE SIMILAR TO THE "INDIAN CHILD WELFARE ACT"

PASSED BY CONGRESS IN 1978. WE BELIEVE THAT IF IT IS GOOD FOR THE CHILD, THEN IT SHOULD ALSO BE GOOD FOR OUR ELDERLY.

4. THE INDIAN HEALTH SERVICE SHOULD BE MANDATED TO BEGIN TO IMPLEMENT LONG TERM CARE FACILITY INVOLVEMENT

CURRENTLY, THERE IS A NEED FOR INTERMEDIATE AND SKILLED NURSING CARE IN INDIAN COMMUNITIES. THESE NEEDS CAN BE MET THROUGH THE DEVELOPMENT OF "SWING BEDS" WITHIN IHS FACILITIES. IHS' RELUCTANCE HAS BEEN DUE TO RECENT FUNDING CUTBACKS AND LACK OF A CONGRESSIONAL CLARIFICATION ON WHETHER THESE ARE INDEED AREAS FOR IHS INVOLVEMENT. WE BELIEVE THEY ARE. IN ORDER TO IMPLEMENT THIS AND OTHER RECOMMENDATIONS, WE FURTHER RECOMMEND THAT AN OFFICE OF GERONTOLOGICAL LONG TERM CARE BE ESTABLISHED WITHIN THE CENTRAL OFFICE OF THE INDIAN HEALTH SERVICE TO MONITOR AND ASSIST TRIBES IN THE DEVELOPMENT AND IMPLEMENTATION OF THEIR LONG TERM CARE PROGRAMS. REGIONAL LONG TERM CARE FACILITIES, WE BELIEVE, COULD ASSIST IN REDUCING THE COSTS OF BUILDING FACILITIES FOR EVERY TRIBE. WE BELIEVE THAT A THOROUGH REVIEW OF THIS OPTION NEEDS TO BE EXPLORED.

5. INCREASED APPROPRIATION AND REAUTHORIZATION OF THE OLDER AMERICANS ACT

THE OLDER AMERICANS ACT, TITLE VI PROGRAM HAS ALLOWED INDIAN TRIBES TO BEGIN TO DEVELOP PROGRAMS FOR THEIR ELDERLY. THESE PROGRAMS ARE DESIGNED TO KEEP THE ELDERLY OUT OF THE NURSING HOME UNTIL ABSOLUTELY NECESSARY. HOWEVER, IT IS CURRENTLY ONLY SERVING 83 TRIBES WITH AN ADDITIONAL 27 TO BE ADDED IN

FY 1984-85. YET FUNDING FOR THIS TITLE IS PROJECTED AT A $7.5 MILLION LEVEL. WE BELIVE ALL INDIAN TRIBES SHOULD BE ELIGIBLE FOR THIS PROGRAM AND THAT A FUNDING LEVEL OF $50 MILLION IN FY 1984-85 IS A NECESSARY FIRST STEP IN THE RIGHT DIRECTION.

6. DEVELOPMENT AND FINALIZATION OF A NATIONAL INDIAN AGING POLICY

WE BELIEVE THAT THE TIME IS NOW TO DEVELOP AND FINALIZE THE POLICY MENTIONED TWO YEARS AGO BY THE ADMINISTRATION ON AGING. WE BELIEVE THAT ALL FEDERAL AGENCIES SUCH AS THE BUREAU OF INDIAN AFFAIRS, INDIAN HEALTH SERVICE, SOCIAL SECURITY, ADMINISTRATION ON AGING, ADMINISTRATION FOR NATIVE AMERICANS, AND HOUSING AND URBAN DEVELOPMENT NEED TO BE INFORMED THAT A NATIONAL COMPREHENSIVE POLICY NEEDS BE DEVELOPED AND SUBMITTED TO CONGRESS BYJUNE 1985.

MR. CHAIRMAN THIS CONCLUDES MY REMARKS. I APPRECIATED THE OPPORTUNITY TO MEET WITH YOU AND DISCUSS THE ISSUES RELATED TO OUR GROWING ELDERLY INDIAN POPULATION. I HOPE I HAVE REPRESENTED THE ELDERLY OF LAGUNA WELL . . . I HOPE THAT WHEN I GO BACK AND TOUCH THEIR WRINKLED HANDS, I WILL SAY, "THEY HAVE LISTENED, THEY HAVE HEARD AND THEY WILL HELP YOU."

THANK YOU.

19 TRIBES

*INTER TRIBAL COUNCIL*
*of*
*ARIZONA, INC.*

June 6, 1984

Jorge J. Lambrinos, Staff Director
Select Committee on Aging
U.S. House of Representatives
HOB Annex 1 Rm. 712
300 New Jersey Ave. S.E.
Washington, D.C. 20515

Dear Mr. Lambrinos:

Enclosed is a statement from Inter Tribal Council of Arizona's Area Agency on Aging component.

Please include this on record of May 25, 1984 Joint Hearing of the House Select Committee on Aging and the Committee on Interior and Insular Affairs.

Sincerely,

John R. Lewis
Executive Director

124 West Thomas Road • Suite 201 • Phoenix, Arizona 85013 • (602) 248-0071

## Statement to the Joint Hearing of the House Select Committee on Aging and the Committee on Interior Insular Affairs

May 25, 1984

### Background

The Inter Tribal Council of Arizona, Inc. is an Area Agency on Aging that administers Older Americans Act Title III funds for 17 tribal governments in Arizona. In this capacity the Inter Tribal Council of Arizona, Inc. has explored the concerns of and programs for the Indian elderly in Arizona and has assisted tribes in coordinating multiple resources to deliver aging services.

Currently approximately 200 Indian elderly are placed in institutional care off reservations. The long term care priority of Indian people is to care for their elderly in their own tribal communities. Any consideration of long term care issues must start with the perception that alternatives to off reservation hospitalization and nursing home care are primary concerns. Additionally, the financing of nursing home construction and operations are prohibitive and are not feasible for most tribes. Innovative services such as hospital swing beds, home health care or intertribal skilled care facilities should be explored.

### Resource Coordination

The tribes in Arizona use a mixture of Older Americans Act Title III, Title VI, Social Services Block Grant Title XX and other tribal funding sources to provide community based services for elderly Indian persons statewide:

## FUNDING FOR TRIBAL SERVICES FOR INDIAN ELDERLY

| Tribe | Individuals over Age 60 | OAA Title III | OAA Title VI | SSBG Title XX |
|---|---|---|---|---|
| Ak-Chin | 25 | $ 9,020 | -0- | $ 11,344 |
| Camp Verde | 50 | 21,156 | -0- | 17,517 |
| Cocopah | 35 | 11,560 | -0- | - |
| Colorado River | 260 | 60,947 | -0- | 26,038 |
| Fort McDowell | 35 | 11,560 | -0- | 11,989 |
| Fort Mojave | 51 | 6,761 | -0- | 15,132 |
| Gila River | 554 | 66,530 | -0- | 100,105 |
| Havasupai | 40 | 12,294 | -0- | 12,200 |
| Hopi | 74 | 64,904 | 71,366 | - |
| Hualapai | 57 | 29,504 | -0- | 21,796 |
| Kaibab-Paiute | 16 | 7,765 | -0- | 9,282 |
| Papago | 1,283 | 121,100 | 70,125 | - |
| Pascua Yaqui | 87 | - | 68,546 | 21,044 |
| Quechan | 116 | (Services from Inter Tribal Council of Calif.) | | |
| Salt River | 187 | 20,250 | 62,980 | 33,067 |
| San Carlos | 430 | 73,932 | 61,966 | 99,592 |
| Tonto Apache | 4 | 5,255 | -0- | 8,706 |
| White Mountain | 376 | 102,102 | 68,546 | 124,312 |
| Prescott-Yavapai | 5 | 4,595 | -0- | 9,029 |

In Arizona, all twenty tribal governments operate programs for the elderly. Eighteen tribes use Title III funds, which are passed through the State of Arizona, and through two Indian Area Agencies on Aging, one for Navajo, and one for the ITCA member tribes. Tribes with fewer than 1,000 members receive a base amount of funds for administration which is added to a per capita distribution. This allows even the smallest tribes to deliver aging services.

All tribes in Arizona receive Social Service Block Grant Title XX funds. Ten of these tribes use most or all of their Title XX funds for services to the elderly. Six Arizona tribes use Title VI funds. One tribe receives Title VI but no Title III funds. That tribe supplements its elderly services funds with Social Services Block Grant Title XX.

In addition to the resources mentioned above, tribes also use Community Health Representatives funds from Indian Health Service to deliver community outreach and home health care for the elderly. All tribes provide tribal funds to support services for the elderly.

More flexibility is needed to allow Indian tribal governments to coordinate Older Americans Act Title III and Title VI funds to provide services to elderly reservation residents. Title VI does not provide sufficient resources to meet the needs for social services, homemaker, chore services and nutrition services for the elderly.

Title VI regulations are restrictive. Eligibility for Title VI funding is limited by law to tribes with more than 75 members above the age of 60, or to consortia with service populations of 75 elderly. In view of this restriction only three of the 13 tribes not utilizing Title VI in Arizona are eligible for direct federal funding for elderly services.

Title VI and Title III funds cannot be combined and administered as a single source, yet the service goals for both titles are essentially the same. All but one of the six tribes who receive both Title III and Title VI were already operating with Title III before Title VI became available. Title III did not provide sufficient funds to serve the elderly population. To utilize Title III and Title VI funds, in practice, tribes have been required to implement geographically separate programs using these resources. The elderly still ask questions about why they cannot be served in certain sites on their reservation.

All tribal governments in Arizona make services for Indian elderly a top priority. Without exception, tribes in Arizona make strong efforts to coordinate Title III resources with other resources. Typically, the economic value of services to the elderly on Indian reservations is two to three times the amount of Title III funds available. Tribes are in the best position to decide on the appropriate mixes of social services and nutrition services for the elderly.

Requiring separate reporting for Title III B, C-I and C-2 does nothing to improve services and imposes unnecessary administrative burdens and costs on tribes. The reporting requirements should be consolidated.

Recommendations:

1. The Older Americans Act should be amended to allow tribal governments to coordinate Title III and Title VI.
2. Title VI and Title III of the Older Americans Act should be amended to permit application for direct program funds by any federally-recognized Indian government, regardless of the size of its service population.
3. Title III of the Older Americans Act should be amended to treat all funds in the Title as one source, rather than as three sources. (III-C I, III-C 2 and III-B)

Intergovernmental Coordination

The availability of Title III and Social Services Block Grant Title XX funds to tribal governments in Arizona is possible because of a carefully developed system of intergovernmental relations between the tribal governments and the State of

Arizona. This system includes the use of a State/Tribal Intergovernmental Agreement for program funding using federal pass-through dollars. This Intergovernmental Agreement recognizes the legal and political status of tribal governments, does not require disputes to be settled in State courts, and allows tribes to exercise Indian preference in hiring. However, this system is fragile and vulnerable to political changes.

As a long range concern, we would like to see stability built into the tribal human services system through direct federal funding to Indian tribal governments for both Older Americans Act Title III and Social Services Block Grant Title XX funds. In the interim we urge the proposed Special Assistant in the Office of the Commissioner on Aging to recognize the importance of tribal/state/federal intergovernmental coordination of Title III, Title VI, Title XX, Indian Health Service and other resources.

Recommendations:

1. All legislation and policy governing federal aging programs should provide tribal governments, regardless of size, the option for direct federal program funding.
2. A percentage of federal program funds should be set aside and made available to tribal governments.
3. Federal allocation formulas for the distribution of human service funds should include a base amount for small tribes, in order that small tribes may apply for and administer programs.

## Home Health Care

In Arizona, the availability of Title III and Title XX resources, and the resultant development of human services on Indian reservations delivered by tribes, has increased the human services delivery and management capabilities of tribal governments. Fourteen tribes contract with the BIA under PL 93-638 to operate social services programs.

Tribes have emphasized preventive and in-home support services to enable elderly Indian people to remain in their homes. These preventive and in-home services have been coordinated with Community Health Representatives outreach and home health services, and with Older Americans Act social and nutrition services. Tribes need to improve and expand their home health service for the elderly.

## Recommendation

Medicare Home Health Agency funds should be made available to Indian tribes to enable them to develop comprehensive home health agencies to provide services to both the elderly and younger disabled Indian reservation residents.

IN REPLY REFER TO:

PUEBLO DE ACOMA
"THE SKY CITY"
P.O. Box 309
ACOMITA, NEW MEXICO 87034

TELEPHONE (505) 552-[illegible]

OFFICE OF THE GOVERNOR

GOVERNOR
Merle L. Garcia
FIRST LT. GOVERNOR
[illegible]
SECOND LT. GOVERNOR
[illegible]
SECRETARY
Robert T. Garcia
INTERPRETER
[illegible]

JUN 13 1984

May 25, 1984

Representative E.R. Roybal
United States House of Representatives
House Committee on Aging
2217 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Honorable Representative Roybal:

Attached is a copy of our statements on behalf of the Pueblo de Acoma to be made a part of hearing testimony presented before your committee in Tucson, Arizona.

I am confident you will find these remarks represent the views of a substantial portion of the Native American governments in the United States.

Sincerely,
Merle L. Garcia

Merle L. Garcia
Pueblo de Acoma
Governor

glg

xc: Office File

# TESTIMONY BEFORE THE HOUSE SELECT COMMITTEE ON AGING
# "LONG TERM CARE PUBLIC ISSUES: THEIR IMPACT ON HEALTH & SOCIAL SERVICES FOR ELDERLY INDIANS"

The Statement of
Merle L. Garcia, Governor
of
Pueblo de Acoma

At
University of Arizona
Student Union Senior Ballroom
Tucson, Arizona

May 25, 1984

IN REPLY REFER TO:

PUEBLO DE ACOMA
"THE SKY CITY"
P.O. Box 309
ACOMITA, NEW MEXICO 87034

TELEPHONE (505) 552-6606

OFFICE OF THE GOVERNOR

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[illegible]
SECRETARY
Robert T. Garcia
INTERPRETER
[illegible]

TESTIMONY BEFORE THE HOUSE COMMITTEE ON AGING
PRESENTED BY:
MERLE L. GARCIA, GOVERNOR
PUEBLO DE ACOMA
May 25, 1984

On behalf of our Acoma people and the wonderful State of New Mexico, I am indeed pleased to be able to present this brief testimony before you today. We as leaders of our people and advocates for American Indians throughout this country are obligated every now and then to present our concerns and needs as expressed by those we serve.

As the traditionally appointed leader of my people, the Pueblo de Acoma, I can effectively relate to the many problems and concerns we are faced with during this time and age. However, unlike the elective process we are all so familiar with in selecting a President of the wonderful United States, the leaders of the Pueblos are appointed by a system thousands of years old. The sacred group of our traditional religious society known as the Cacique bestowes upon selected individuals of the Pueblo the responsibility of leadership, sometimes against the individuals' will or desire. Nonetheless, we who are appointed, are very happy to be able to serve our people.

Many aspects of our way of life are unchanged and have withstood time, human intervention and yes even "Mother Nature". An outstanding example of this endurance is our famous pueblo, "SKY CITY". This Pueblo is the oldest continuously inhabited community in the Northern Hemisphere. The experience of standing in the midst of this living historic site is extraordinary and to many who have visited the site, feel the experience to be very spiritual. I know the spiritually of "Sky City" as being real and the endurance of my people is an example of what this great land can and will provide for all our people, Indian and non-Indian alike.

I want to thank the committee for the opportunity to testify today before the House Committee on Aging sponsored by Rep. Roybal, California Chairman. We feel the importance and the need to support Indian Long Term Care.

In the United States today, there are an estimated 109,000 Indians age 60 and over. In 1970, this population numbered a mere 64,000. In one decade there has been an increase in this population of approximately 71%. It has been indicated in various studies by experts in the field that at any given time, almost 5% elderly people age 60 and over are institutionalized. If applied to the Indian community, it is estimated that approximately 4,360 are in long term care facilities at any given time. Concurrently, there are only eight long term care facilities on Indian reservations today with a total bed capacity of 410 beds! Obviously, Indian elderly are being placed in non-Indian facilities away from the Indian communities. Six Acomas have been placed and a total of 30 elderly have been placed area wide. There are 229 Acomas who are over 60 years of age.

Needless to say, we can see that the elderly are a growing segment of the Tribal population, and as such health problems for this segment of our population will increase. Many of the other prioritized programs will need to integrate and cooperate with the goal of this program, and be supportive of its objectives. Perhaps, falls can be reduced through the Accident program, or a better sense of belonging and value can be established through mental health approaches under the Alcoholism Program. Certainly, prevention through Health Education and the increase of needed medical services will bring sharper focus to these programs.

It would be both simplistic and accurate to say that the elderly Acoma tribal population need more of everything. The present program is both under-staffed and under-utilized, and is confined to central kitchen feeding, some meals are taken to those who are home bound, and an effort is made to provide physical conditioning. However, this is but a small effort when one considers all the potential and need for programs that will keep the valuable resources that is the elderly, active in tribal society.

The elderly are a valuable resource, representing knowledge, attitude and skills that exist not on paper, but only in their being. They better understand the tribal language, the history, the stories that formulate the cultural traditions, the ceremonies that lend richness and color to the value that comes with being an Acoma. Much of the above is lost each year, each time an elderly person dies, each time they do not participate in tribal affairs.

Elderly need a place to go that will help them to feel valuable and to gain identity with the tribe and others of their age. A proposed elderly/youth and long term care center where they could get nutritious food, find leisure time activities, communicate with each other, and participate in activities needed for sound mental and physical health would be very beneficial for our elderly people.

In describing our area and homeland, you will realize how a proposed elderly/youth long term care center would be most beneficial to our people. Acoma Pueblo is regarded as "high desert" country, with a varied composition of geographic formations, timber, grasslands, croplands, small communities, streams, lava flows, sandstone, mountains, arroyos, mesas, and start escarpments. It is a big country, with few roads to link it's 3808 citizens. While the communities of Acomita, McCartys and Anzac boast of having most of the tribal population, many still retain their homes at Old Acoma "Sky City", while some Acomas prefer the isolation of dirt road, remotely linked over miles of sagebrush and pinion trees to the nearest neighbor.

Along the northern portion of the tribal lands cuts the Santa Fe Railroad with no scheduled stops and a major highway, Interstate 40, linking Albuquerque 60 miles to the east; and Grants and Gallup 15 and 75 miles respectively to the west. Sheep, cattle and agriculture (primarily small family gardens) mark the local industry, with a handful of general stores that resemble trading posts, a few gasoline stations, restaurants and roadside motels supplying employment on reservation or adjacent areas to those who do not work for the government. Some travel daily to Albuquerque for assorted jobs, while more work in service positions in Grants. The uranium and potash mines near the reservation also provided employment. Out of potential labor force of approximately 730 people, only 250 of the people are employed, mostly in jobs classified as labor or skilled labor however, there are 480 who remain unemployed. As a result of low employment possibilities on the reservation, the needs to travel for other off-reservation jobs, and lower wages paid for these positions, the economic level of over 86 percent of the families is poverty. The per capita income is approximately $2,500 per year.

As a result of the combination of geography and income, many people have no automobile vintage, pickup trucks dominate the dirt roads, and few trips are made away from the tribal lands. Houses are modest, often constructed of local stones with dirt floors, and have no running water or indoor plumbing facilities. Few students graduate from high school and fewer from college. Those who often do not return to the reservation do so because of low employment opportunities on the reservation.

1. What and how should the various Federal Agencies begin to coordinate their resources to ensure the availability of long term care facilities within the Indian community:

   PUEBLO DE ACOMAS RECOMMENDATION:

   1-1. The Federal agencies; mainly, IHS and BIA should begin coordinating efforts with tribal resources to develop plans for a long-term care facility or an alternative for the elderlys.

   Specific identification of the facility should be made meaning a non-medical care vs a medical care facility. From experience, most of the long-term facilities do have medical professions on staff however the Bureau does not allow payments to this type of a facility, thereby eliminating appropriate medical care for the Elderly.

   The tribe should determine the type of facility they would operate and draw up their standards, then negotiate with IHS and Bureau for payment of care, as both agencies have the responsibility for payment of care, - IHS for medical portions and BIA for custodial care. I feel that determination of payment should not be based on the client's own income/resources to apply to the cost of his/her care. If the client has medicare/medicaid it can be made applicable, but to use their Social Security or other retirement benefits for payment for all part of the cost should not be applicable.

2. What and how should the various Federal Agencies begin to coordinate their efforts and resources to ensure the development of alternatives to long term care facilities?

   2-1. The Federal Indian directed agencies should begin working closely with HHS department agencies - and especiall medicare - to help curb the rising costs of tax supported medical treatment. Special attention should be devoted to attempts to provide in-home care for the elderly. In this regard, expansion of programs such as community health representative (CHR) may prove useful.

3. What are the barriers to the two previously mentioned issues and how can they be resolved? what issues can be resolved administratively? Statutorily?

   PUEBLO DE ACOMAS RECOMMENDATION:

   The Pueblo de Acoma has implemented a division of Health & Social Services within the overall Acoma tribal structure. The Reservation is part of District III of New Mexico, State Health System Agency and Middle Rio Grande Council of Governments Acoma has established and maintained close coordination and relationships with Indian Health Service, BIA, State and local governments.

   - Racism - Indian are very reluctant to go for services from agencies or persons that are unsympathetic or even hostile.

   - culture barriers - most services provided by non-Indian people are not culturally sensitive.

   - That policies issued by the State have Indian input.

The Federal agencies mentioned above are pulling in each direction and want the other to have the primary responsibility.

In order to resolve the issue, I feel that a tribally operated long-term facility, with the involvement of the federal agencies will be more accessible to clients and families, and be better controlled with effective and quality services, including some professional medical staff or availability of immediate medical service when needed.

4. What has been the position of the Bureau of Indian Affairs regarding long term care? Are its definitions of the different levels of care (e.g., skilled, Intermediate, Custodial) consistent with current definitions used by the Health Care Financing Administration?

PUEBLO DE ACOMAS RECOMMENDATIONS:

The position the Bureau has taken, that it has to be non-medical setting(custodial care) before they can make any payments. Determination of payment is as follows in 66 BIAM 5.10C:

C. Determination of Payment

1. Authorization for payment for all or part of the cost of custodial care should not be made until full determination of eligibility has been completed. This determination shall include:

    (a) A determination of availability of client's own income and resources to apply to the cost of care.

    (b) A determination of client eligibility for public assistance; SSI, medicaid and medicare.

2. Where homemaker/housekeeper services are to be provided in accordance with a plan by the Bureau, payment may be made to purchase such services. The total payment shall not exceed the cost of Class I Custodial Care that prevails in the state of residency. Payments may be made directly to the client or purchased by vendor payment."

   The Class I Custodial Care encompasses protection and personal services in addition to food, shelter, laundry and related cost. This type of definition being employed by the BIA manual is not benefitting the Indian Elderly and needs to be completely "wipe-out" and restated according to Indian concerns and desires.

5. Many elderly Indians residing in long term care facilities need the services of Medicinemen in conjunction with western medicine. The costs associated with providing this mode of medical care is not reimbursable under Medicare. What efforts need to be initiated to ensure that these services are reimbursable?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

No reimbursable for medicinemen with medicine, tradition passed from generation to generation to privide these types of services.

6. Medicaid reimburses long term care facilities based on bed occupancy. If the bed is vacant, it is not reimbursable. Most Indian communities are isolated

and when families take their elderly home for visits, especially in inclement weather, their visits exceed the number of days that they are allowed to be away from the facility - therefore, the long term care facility is not reimbursed for that vacant bed. What can HCFA do to ensure that these environmental/climate circumstances are considered in the reimbursement policies?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

All the clients that are in long-term facilities are medicaid recipients. If the client is home for a visit, he/she is still charged during his absence and if they stay three (3) days beyond authorized visit for whatever reason, they are released from the services and if he/she wishes further services, they are put back on the waiting list and have to wait. They are not charged during the time they are on the waiting list, but causes a disruption of services. Therefore, there should be instituted a more coordinated effort so as to cause the less disruption of services to the elderly. Also special circumstance should be allowed for in policy development affecting continued services rather than the present process of having to be penalized by being put on a waiting list.

7. Due to the "recentness" of long term care facilities in the Indian community, there is a lack of qualified Indian professionals in the field of long term care. What are the Administration on Aging's plans to implement training activities to ensure that a cadre of professionally trained Indians are available? The IHS?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

IHS should take late considerations from individuals who wish to be trained or are qualified individuals that have been retrieved from service and could be utilized to fill full-time positons with IHS at medical facilities. There should be separate funding for aging educational assistance to dealing mainly with the Elderly. Also, refund individuals that are lacking semester hour, clinical hours, to let them finish schooling.

No training specifically geared towards long-term care have been provided to the tribe by IHS or any other agency. Acoma has about five (5) members who have worked in this typed of setting giving direct care.

8. In some Indian communities, IHS facilities are not used to its maximum capacity. At times there are empty beds that are not utilized. What are barriers to the utilization of these beds as "swing beds" by the facility to ensure that the long term care needs of the Indian people are met?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

True - IHS doesn't have enough or adequate funding to run their facility or there is a lack of professional people. The ones that need the manpower or monies are never considered. It always goes to some other department that does not do anything of value.

In-patient care is provided indirectly through contractual arrangement in community hospital with Indian Health Service, negotiating contracts on a reimburseable basis. In order to maintain an adequate level of contract services a total amount of $367,400 is required for the ACL Hospital.

IHS facilities are very reluctant in providing custodial care to elders, unless it's medically related, even if all hospital beds are empty.

9. The cost of providing institutionally-based services are more costly than similar services provided in urban or non-Indian communities. What can be done by HCFA to ensure that cost reimbursement formualas take into consideration these deviations from the Norm?

PUEBLO DE ACOMAS RECOMMENDATIONS:

This question requires a health care administrators professional opinion. The key problem is: Why is the assumption in the question true. Why does institutional care for Indian people cost more than for non-Indian communities? Certainly the answer is not that the care is 'better". The problem is not deviation from the reimbursement norm - it is deviation from the quality - of - care norm.

10. With the increasing elderly population within the Indian community thus increasing the need for nursing home beds. What should the federal grovernment's response be to this need?

PUEBLO DE ACOMAS RECOMMENDATIONS:

In order for the federal government to provide assistance to the Elderly they should without hesitation give fundings to tribes that request monies to build nursing homes or funds to renew nursing homes be given with no cut back. Because Elderly have no place to go or others seek shelter in order for someone to take care of them.

11. To ensure that the medical needs of the elderly residing within long term care facilities are met, some Indian facilities have or are utilizing the medical resources of IHS. However, the IHS facilities providing these services while reimbursed by Medicare or Medicaid, are not benefitting from the reimbursements generated and thereby assist in offsetting these costs. This due to the procedures utilized by IHS in the redistribution of these reimbursements. What can be done by IHS to ensure that the funds are returned to the facilities generating these third - party reimbursements?

PUEBLO DE ACOMAS RECOMMENDATIONS:

Third party reimbursements may be an alternative means of collecting needed operating and support funding; however, presently our local hospital benefits very little from the Medicare and Medicaid Programs. This is due to the fact that third party reimbursement payments are reimbursed back to the United States Treasury not directly back to the affected health providing facility.

Very few of our community members are eligible for coverage under Medicare and Medicaid or any third party reimbursement, as such we support the traditional arrangement of service availability to all eligible Indians as part of the Federal Government's trust responsibilities as agreed to in our treaties and other related agreements.

12. Standards applicable to non-Indian service providers are applied to IHS, this making the provision of certain medical services difficult and cumberson for IHS personnel. What should the HCFA do to reduce this duplication of standards and thereby facilitate the provision of needed medical services?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

HFCA could examine the standards which should apply to IHS. I am however not sure that separate standards for Indian Health care is a desirable goal. History has shown that separate standards lead to sub-standards for someone - probably the Indian. I would recommend that internal administrative procedures be looked at to assure that the equal standards are met.

13. The application of non-Indian urban and definitions regarding levels of care are inappropriate to the Indian community (e.g. Individuals needing an intermediate level of care is different in the Indian community compared to non-Indian communities) What should HCFA implement to ensure that the long term care needs of Indian elderly are accurately defined and determined?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

Our position on this matter of defining levels of care was adversed in item #4 above.

14. The Nursing Home Residents Bill of Rights require that certain activities be implemented to ensure that the elderly Indians in non-Indian long term care facilities increases the potentially of compromising the rights of elderly Indian residents. What should be done to ensure that their rights are protected? By whom should this be enforced?

PUEBLO DE ACOMA'S RECOMMENDATIONS:

I have heard of the Nursing Home Residential Bill of Rights, but I am not aware if there is any Bill that is specifically geared towards the ensurance of elderly Indians rights in a non-Indian long-term care facility.

As stated before, to ensure quality and efficient long-term care services to the elderly, is to plan an on-the-reservation care facility, including training for staffing from Administrator down to direct service providers and maintenance of such a facility. The reason for this, is because most of the long-term care facilities are state operated, or they are operated by the private sector which makes it difficult to change any rules, regulations, guidelines, etc., that they have.

These problems as identified and recommendations as defined are items we believe can be easily implemented without adverse effects to existing programmatic activities. Your most favorable and timely attention to these concerns is most certainly appreciated.

Respectfully submitted,

Merle L. Garcia

Merle L. Garcia
Governor

# A STUDY TO DETERMINE THE FEASIBILITY OF CONSTRUCTING A 50-BED NURSING HOME ON THE PAPAGO RESERVATION

Prepared by

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## Background of the Report

A representative from the Papago Tribe recently contacted the Arizona Long Term Care Gerontology Center and requested assistance in determining the feasibility of constructing a 50-bed nursing home on the reservation in Sells, Arizona. Although tribe members prefer to keep those who develop mental or physical impairments in the community, this is not always a satisfactory arrangement. Some of the chronically ill in need of supervised care may not have family members able to care for them. Others may have conditions requiring institutional nursing care. At present, those needing care must be placed in facilities located a considerable distance from the reservation. Since the Papagos would prefer to have their own facility, the Center was asked to conduct a study which would assist the tribe in deciding whether or not to construct a 50-bed nursing home on the reservation.

The Arizona Long Term Care Gerontology Center, one of nine centers supported by the Administration on Aging, has been operational since 1981. It is a community-based organization whose primary purpose is to improve the quality of life for the elderly, whether at home or in an institution. Center staff members have expertise in planning aging services and programs and in providing technical assistance to community groups such as the Papago Tribe when requested.

This report compiles information about the health care resources for the elderly and handicapped Papago, the current long term care situation, future chronic care needs and the feasibility of building and operating a long term care facility on the reservation; options to institutional care are also presented.

## Demographics of the Papago Tribe

Approximately 60% of the Papago Tribe resides on a large reservation located in south central Arizona. The 3.2 million acre reservation, approximately the size of the State of Connecticut, is predominantly located in Pima County with small portions extending to Pinal and Yavapai Counties. Small satellite reservations are situated at Gila Bend, San Xavier and Florence Village. The village of Sells, located 45 miles east of Tucson, has the greatest population. This is where tribal and federal government agency offices and most health care resources are located.

Although statistics vary from source to source, according to the Indian Health Service (IHS), there are at least 12,691 tribe members of which 769 of those are over the age of 65. The number of elderly Papagos is small when compared with the U.S. population. Elderly Papagos (65+) represent only 5.9% of the total tribe population. Comparative data taken from the 1980 U.S. census reveals that 11.3% of the total U.S. population are now 65 or older. In other words, almost twice as many non-Indians reach 65 as do their Papago Indian counterparts.

A primary factor in the shorter life expectancy of the Papago and in other American Indian tribes is the high incidence of chronic illness. Hypertension, diabetes mellitus, rheumatoid arthritis and heart disease are common among the Papago. Alcoholism is prevalent and contributes to the incidence of chronic disease.

Not only is there a prevalence of chronic illness among many Papago tribe members, these diseases occur much earlier in life than in the general population. This is particularly true for those who live on the reservation. In fact, according to a 1981 study conducted by the National Indian Council on Aging (NICOA), rural Indians age 45 and older have impairment levels similar to non-Indians age 65 and older.[1] Discussions with the Director of Nursing at the American Indian Nursing Home in Laveen, where 31 of the 44 institutionalized Papagos reside, revealed that approximately 50% of the Papago patients were between 35 and 55 years of age. Although the director was unsure where these patients had previously resided, she thought most were from the reservation.

Despite the fact that fewer Papagos survive to old age, data from a 1967 tribal census compared with 1980 U.S. census information indicate a significant upward trend in longevity. The table below illustrates the trend during that 13-year period.[2]

INCREASE IN NUMBER AND PERCENT OF PAPAGOS
ABOVE 65 FROM 1967 TO 1980

| Age | 1967 | 1980 | Increase In Number | Percent Increase |
|---|---|---|---|---|
| 65-74 | 203 | 313 | 110 | 54 |
| 75+ | 118 | 186 | 68 | 58 |
| | | Total | 178 | |

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[1] American Indian Elderly: A National Profile, National Indian Council on Aging, 1981, p. 3.

[2] These data are for reservation Indians only; 40% of the Papagos live off the reservation.

If present trends continue there will be at least 520 Papagos over 65 and 350 over 75 in 20 years. Between 1967 and 1980, the greatest increase in the number of elderly Papagos occurred in the 75+ population who were also the most frail and the most likely to have multiple chronic conditions. In the U.S., approximately 4% of those over 65 reside in long term care institutions. However, those over 75 constitute 20% of the nursing home population. Data indicate that 42% of the 31 Papagos at Laveen are over 75. In fact, the oldest Papago resident at the American Indian Nursing Home is 97. As people age, physical and mental impairments become more common and eventually result in a decreased ability to function independently and an increased need for long term care.

## Cultural Influences Affecting Care of the Elderly

Cultural changes are affecting the care of older tribe members. It seems that young Papagos have adopted attitudes prevalent in the dominant Anglo culture and no longer respect the old ones as they did in the past. A study completed in 1981 indicates that only 6% of elderly Papagos chose to live with a son or daughter. A significant number (29%) prefer to live with relatives other than children.[3] Most elderly persons prefer living with relatives when they are widowed. Despite these stated preferences, according to those Papagos who were interviewed, the number of elderly living alone is increasing.

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[3] Indian Elderly and Entitlement Programs: An Accessing Demonstration Project, The National Indian Council on Aging, Inc., 1981, p. 53.

## Acute and Primary Health Care Resources and Utilization by the Elderly Papago

### Acute Care

A 40-bed, Indian Health Service (IHS), acute care facility is located on the Papago reservation in Sells, Arizona. Services offered include: care of the general medical-surgical patient, uncomplicated obstetrics and pediatrics and care of trauma victims not requiring surgery. There are no surgical facilities at Sells; all elective and emergency surgical cases are taken to Tucson for treatment at a contracted hospital. High risk obstetrical patients, those with life threatening illnesses, and acutely ill infants are also sent to Tucson for treatment. There is no intensive care unit (ICU), sophisticated monitoring equipment nor any trained ICU personnel at Sells Hospital.

Twenty-one to 24 of the facility's beds (56%) are occupied at all times. It is not possible to admit more patients due to current staff restrictions imposed by the IHS, consequently, the facility is underutilized.

The staff includes eight physicians, 18 registered nurses, 11 licensed practical nurses and eight nurse aides. There are also several administrative staff and ancillary personnel. Some hospital employees live on the reservation; others commute from Tucson and surrounding areas.

Staff who were interviewed estimate that three to five beds are consistently occupied by elderly patients. According to a study completed in 1978 by Dr. Felix Hurtado, Medical Director, the average length of stay for the three most common diagnoses of elderly patients (diabetes, circulatory and respiratory disease) was 7.86 days. The fourth most frequent diagnosis at the time of the study was for "social problems." The patient with this diagnosis often has no family or community supports, requires personal care and assistance and has an average length of stay (LOS) of 18.4 days. Patients with "social problems" are usually transferred to nursing homes from the acute care facility.

## Primary Health Care

Ambulatory care is provided at four clinics on the reservation -- Sells Hospital, San Xavier, Santa Rosa and a mobile clinic held once a week in Pisinimo. Examples of specialty clinics which are conducted include ophthalmology, diabetes, hypertension, rheumatology and mental health. According to 1982 IHS statistics almost 60,000 visits were made to the clinics. Three-fourths (75%) of the Papago elderly population were seen at least one time and represent almost 7% of the total visits.

The community health nursing program, funded by the IHS, has a staff which includes a director, nurse practitioner, four RNs and three LPNs. The community health nurses (CHN) serve the entire reservation, traveling long distances between patients.

In addition to conducting clinics for immunizations, vaccinations and assessment of the feet of all diabetics, the CHNs perform the following functions:

- Observe for compliance with prescribed treatments and medications.
- Assess the progress of all prenatal patients (especially high risk mothers).
- Assess and monitor the progress of all diabetic patients.
- Evaluate the growth and development of infants and children.

Each year, between 10-12,000 visits are made. Of that total, approximately 10% are to the elderly.

## Tribal Health Program

This community-based health program, administered by Papago Tribe members, is funded by the IHS. The 23 staff members, known as community health representatives (CHRs) serve all 11 districts on the reservation. There are two workers for each district plus an additional CHR located in Sells. All workers, although trained as home health aides, have job responsibilities in three primary areas. A detailed description of the CHR job functions are provided below.

> Home Visits - For the purpose of assessing general health, monitoring medications, changing dressings, performing physical therapy, scheduling clinic appointments and making referrals, if necessary.
>
> Transportation - This service is for patients who must be driven to and from health care appointments. For example, patients are taken to Tucson to receive dialysis treatments early in the morning and must be retured to the reservation after treatment is complete.
>
> Clinic Assistance - The CHRs assist in the ambulatory care clinics.

Elderly Papagos are served by the tribal health program although statistics on program enrollment, percent of elderly patients or number of visits made were not available.

## Elderly Program

This program is targeted to the elderly Papago and has several components. Established in 1978 and supported with funds from the Older Americans Act (OAA), it is administered by tribe members. The total budget for 1983 was $253,451. Of the 27 salaried staff, 15 are over the age of 55. Services offered under each portion of the program, participants served and allocated monies are listed below.

Title III ($121,000)

Title III Older American Act funds are used for supportive services, senior centers and nutrition programs. The elderly residing in the north, east and south of the reservation receive services at six different sites. All programs are located in and around Sells; remote and sparsely populated areas do not receive Title III services due to limited funding. The services offered and the clients served are as follows:

Congregate Meals - One meal a day, at a different location every day, is served on alternate weeks to a total of 378 elderly. Some socialization activities are included with the meal service. Cutbacks in federal funding necessitated the deletion of home-delivered meals and prevents the expansion of the program into remote areas.

Homemaker Services - Shopping, bathing, dressing, assistance with medications and some housekeeping is available to approximately 30 to 40 people on a regular basis. Services are provided continuously when staff are available.

Transportation - Free trips are available for the elderly once a month. Additional trips are provided if the person is able to pay.

Information and Referral - This component is provided by all staff members. Referrals for social security, food stamps, general assistance and commodities are furnished as needed.

Title V ($66,451)

Title V is known as the Older Americans Community Service Employment Act and provides employment for eligible individuals. Those who are hired must be 55 or older, should be Indian or other minority and must meet low income qualifications. The Elderly Program has 15 part-time workers salaried with money from this title.

Job responsibilities include visitation, light housekeeping, chores and bathing, if necessary. Heavy housework and chores are to be avoided by the older workers. Although Title V workers cover a broader geographical area than Title III workers, remote sites continue to be underserved.

Title VI ($66,666)

This title, specifically enacted to meet the needs of the American Indian elderly is comparable to Title III. It promotes the delivery of social services and nutritious meals. The western and most traditional section of the reservation, where the least English is spoken, is served with funds from Title VI.

Congregate Meals - One meal a day is served at four different locations once a week.

Mobile Meals - Served to the homebound.

Transportation - A small portion is used to provide trips for the elderly.

## Housing and Living Arrangements of the Elderly

Fifty-five percent of the elderly Papagos live in their own homes according to a 1981 study.[4] Many others live with relatives, although the incidence of elderly who live alone is increasing. Apartment dwelling has not been a part of the Papago culture. According to one person interviewed, the Papagos are shy and prefer to live in individual homes apart from one another.

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[4] Indian Elderly and Entitlement Programs, p. 53.

With federal funds from Housing and Urban Development (HUD), six duplexes were recently constructed in Sells for the elderly and/or disabled. Each apartment has one or two rooms, a kitchenette and bathroom. Qualifying renters must be 62 or disabled, yet able to care for themselves. Renters must pay a $50.00 deposit and 30% of their monthly income towards the rent.

The reservation's Housing Authority is responsible for upkeep, maintenance and rent collection of the duplexes. Each unit has an alarm system which rings at the Police Department when activated. The Housing Authority has considered employing a participant in the elderly program to live on the premises and to assist residents in need.

Although the units have been ready for occupancy approximately five months, several remain vacant. Housing Authority staff suggest this may be due to the fact that:

- Renters must live alone or with a spouse.
- The small duplexes can accomodate few possessions.
- Few elderly are willing to relocate to Sells away from family and friends.

There are no additional elderly housing projects being planned.

## Long Term Care Resources and Utilization

For the most part, Papagos continue to support the chronically ill in the community as long as possible. Those who are institutionalized are either too physically or mentally impaired to live alone or may no longer have adequate family supports. According to the IHS social worker at the hospital, most Papagos requiring institutionalization have a diagnosis resulting in some type of confusion. The most common diagnoses at the American Indian Nursing Home are chronic alcohol abuse, organic brain syndrome and stroke, all conditions which can cause mental impairment.

Since there are no long term care facilities on the reservation, when a Papago Tribe member becomes so impaired that placement is necessary, an off-reservation nursing home must be selected. The facilities currently utilized are in Phoenix, Laveen and Tucson, Arizona. Placement in any of these homes creates a hardship on the family and on the person who requires care. Few elderly persons have cars and must rely on others for transportation to visit their family members. Consequently, it is inconvenient, expensive and time consuming to visit Papagos in any of the nursing homes. As a consequence, the tribe member who is a nursing home resident has few visitors and is often lonely.

Although three of the four nursing care facilities admit Papagos, most residents are not American Indians. Since many elderly Papagos continue to practice traditional ways, eat traditional food and speak little English, living in an environment which does not support cultural differences is both alienating and depressing. Family members and patients complain that residents are not treated with dignity or respect. Friction is often created between staff and family when large groups visit and traditional ways are practiced at the institution.

The first choice for placement is the American Indian Nursing Home in Laveen, Arizona. This not-for-profit, church-supported home on the Maricopa reservation admits Indians from ten different American tribes. Staff members are sensitive to traditional ways and practices. Unfortunately, it is 145 miles from Sells and takes three hours to reach. However, since it is preferred over non-Indian homes, the Laveen facility is usually filled to capacity and often has a waiting list.

The chart below presents information about the number of Papagos currently in long term care facilities, the location of facilities and the costs of the care.

| Facility | Number | Cost Per Day | Annual Expense |
|---|---|---|---|
| Skilled Nursing | | | |
| American Indian Nursing Home | 6 | $37.91 | $ 83,022,90 |
| Forrester's Old Pueblo | 8 | $41.00 | 119,720.00 |
| Monterey Nursing Home | 2 | $41.00 | 29,930.00 |
| Intermediate Care | | | |
| American Indian Nursing Home | 13 | $38.39 | 182,160.55 |
| Personal Care | | | |
| American Indian Nursing Home | 5 | $27.02 | 49,311.50 |
| Board and Care | | | |
| American Indian Nursing Home | 7 | $16.46 | 42,055.30 |
| Homestead Nursing Home | 1 | $35.00 | 12,775.00 |
| Foster Care | | | |
| Private Home (off reservation) | 2 | $14.70 | 10,728.00 |
| TOTALS | 44 | $32.67* | $524,703.00 |

*Average daily cost.

Sixteen of the total Papagos in institutions (36%) require skilled nursing care. An additional 13 tribe members (30%) need an intermediate level of care. The remainder are not as dependent and can live in a less supervised environment such as a personal care, board and care or a foster care home. Total annual long term care expenditures are $524,703 at this time.

The actual number of tribe members in long term care facilities may not reflect the true need which exists. Conversations with workers from the elderly program indicate there are many elderly with impairments who continue to live in the community. These people may benefit from and may be more willing to enter a reservation home.

## Sources of Payment for Long Term Care

Payment for long term care for the Papago comes from a variety of sources. The four most common funding mechanisms are listed below:

| Agency/Program | Services Provided |
|---|---|
| Pima County | Payment for all levels of care is provided if the patient meets programmatic and financial criteria. |
| Medicare | Will pay for skilled nursing care for up to 100 days after hospitalization if the patient is eligible for benefits. |
| Bureau of Indian Affairs | Funded through the Tribal Human Services Department, the bureau will pay for all levels of care except skilled. |
| Indian Health Service | Will pay for skilled nursing care if not accepted by any other agency. |

The IHS has become more and more reluctant to pay for long term care in recent years. Federal budget cutbacks are primarily the reason given for this change in policy. When a Papago requires skilled nursing care at a long term care facility and is not eligible for Medicare, county eligiblity is sought by the social services department. Attaining county eligibility is a laborious process often requiring several months. In the interim, the patient usually occupies an acute care bed at the IHS hospital in Sells. If the patient is determined to be ineligible for the county program, the IHS will assume skilled nursing care payment and the patient is transferrd to a long term care facility.

The Bureau of Indian Affairs (BIA), which provides many types of assistance to the Papago will pay for nursing home care below the skilled level. The BIA currently pays for several patients in intermediate care, personal care, board and care and foster care facilities.

## Summary

Characteristics of the Papago Tribe contributing to the need for long term care services include: a high incidence of chronic illness, increasing life expectancy and cultural changes resulting in a younger generation less willing to care for those who have impairments. The number who are in nursing homes may not reflect the true need which exists since conversations with the elderly Program workers suggest others in the community may need an institutional setting. However, there are now only 44 Papagos in long term care facilities.

Acute health care and primary health care are provided to all Papagos including the elderly by the IHS. There is an acute care facility in Sells and several primary health clinics at four diffierent reservation sites. A tribal community health representative program, an IHS community health nursing program and the AoA-funded elderly program provides a minimal amount of home care to the elderly. Insufficient funding of these programs limits the staff and the quantity of available service. Many times, younger patients at high risk (i.e., diabetic pregnant women) take precedence over the elderly.

Long term care (institutional) patients are placed in nursing care facilities located far from the reservation. This situation is inconvenient for both patients and family. Transportation to the facility is time consuming and costly; as a result, patients often feel isolated and lonely.

It is easy to understand why the tribe would prefer to have a nursing home on the reservation. A Papago owned and operated home would decrease transportation costs and travel time and might increase the amount of family visiting. As a result, the nursing home resident would not be so lonely; traditional foods could be served and traditional customs observed at the Papago home. This would decrease the sense of alienation many residents now experience in non-Indian homes.

The next section of this report discusses the feasibility of constructing and operating a 50-bed nursing home on the reservation.

## Construction Costs and Considerations

The Papagos, interested in constructing a reservation nursing home for several years, have selected a site for the proposed facility. It is a tract of land in Sells located near most of the major health resources, approximately one quarter of a mile from the acute care hospital. Directly adjacent to the tribal community health and elderly programs, it is accessible to water and electricity. The site, already the most populous part of the reservation, continues to grow rapidly. Many who lived in remote villages are migrating to Sells to be closer to health facilities, various government offices and schools. For all of these reasons, Sells is the most logical construction site for the proposed facility.

A floor plan for a 50-bed nursing home was designed by CNCW architects of Tucson for the tribe. In addition to the main building, the plans include two additional wings: a fully equipped physical therapy department and a dining room with cafeteria, arts and crafts, staff lounge, administrative offices and other facilities. This particular design could also accommodate an adult day care program. Design plans have been attached to this report.

Estimated capital expenditures for a 50-bed nursing home without frills is more than one million dollars. Depending on design features and purchased equipment, costs could escalate to three million dollars. Aspects of the CNCW design which would significantly inflate construction costs are the two additional wings described above.

Construction and finance costs for a basic facility with no frills is included below.

## CONSTRUCTION AND FINANCE COSTS FOR A 50-BED NURSING CARE FACILITY

### Building Construction Costs

50 Units
275 Square Feet Per Unit
Development Costs Per Square Foot - $75.00

| | |
|---|---|
| Development Costs | $1,106,250 |
| Equipment 50 Beds ($2,200/Bed) | 110,000 |
| Total Costs | $1,216,250 |

### Building Finance Costs

| Interest Rate | Int. Expense Per Year | Monthly Payment | Annual Payment |
|---|---|---|---|
| 10% | $121,041.13 | $10,327.74 | $123,932.88 |
| 11% | $133,173.49 | $11,290.38 | $135,484.56 |
| 12% | $145,303.21 | $12,265.88 | $147,190.56 |
| 13% | $157,430.31 | $13,251.22 | $159,014.64 |
| 14% | $169,555.02 | $14,243.98 | $170,927.76 |

Current costs for constructing a 50-bed facility with 275 square feet per unit, including $2,200 for equipping each unit would be $1,216,250.

The annual costs of financing the building could be as low as $123,932.88 if a 10% loan were obtained and as high as $170,927.76 if a 14% interest rate were obtained. The operating budget which follows utilizes a 13% interest rate to calculate monthly expenses.

## Operating Costs of a 50-Bed Facility

An estimate of annual operating expenses and anticpated revenue will assist in determining whether the nursing home will be self-sustaining. The floor plan designed by CNCW shows a nursing home with three levels of care (skilled, intermediate and personal care).

Since it is more cost effective to maintain a facility with one level of care, key portions of an operating budget for a 50-bed intermediate care facility (ICF) are described below; staffing ratios are average for an ICF in Arizona. Major expenses in this budget are salaries, yet there are no social workers, physical therapists or other ancillary staff included. Although additional staff might enhance the quality of care, it would significantly increase costs.

## PERSONNEL BUDGET

| Staff | F.T.E. | Hourly Rate | Monthly | Annual Expense |
|---|---|---|---|---|
| Dir. Nursing | 1 | | 1,800.00 | 21,600.00 |
| LPN | 4.2 | 6.50 | 4,731.91 | 56,782.91 |
| Nursing Asst. | 16.36 | 4.00 | 11,342.72 | 136,112.58 |
| Med. Rcrds./Ward Clk. | 1 | 4.50 | 779.99 | 9,359.82 |
| Total Nursing | | | 18,654.61 | 223,855.31 |
| Laundress | .5 | 3.75 | 324.99 | 3,899.93 |
| Housekeeper | 2 | 3.75 | 1,299.98 | 15,599.70 |
| Janitor/Maint. | 1 | 5.50 | 953.32 | 11,439.78 |
| | 1 | 4.25 | 736.65 | 8,839.83 |
| Total Housekeeping | | | 3,314.94 | 39,779.24 |
| Dietary Supvsr. | 1 | 6.35 | 1,100.65 | 13,207.75 |
| Cooks | 1.8 | 4.50 | 1,403.97 | 16,847.68 |
| Diet Aides | 2.8 | 3.50 | 1,698.63 | 20,383.61 |
| Total Dietary | | | 4,203.25 | 50,439.03 |
| Administrator | 1 | | 2,000.00 | 24,000.00 |
| Bookkeeper | 1 | 6.00 | 1,039.98 | 12,479.76 |
| Secretary/Recept. | 1 | 4.50 | 779.99 | 9,359.82 |
| In-Service Train | 1 | 7.25 | 1,256.64 | 15,079.71 |
| Total Administrative | | | 3,076.61 | 36,919.29 |
| Act. Dir./Driver | 1 | 5.50 | 953.32 | 11,439.78 |

(Funds are transferred to the operating budget.)

## OPERATING BUDGET

| | | Annual | Benefits |
|---|---|---|---|
| **Expenses** | | | |
| Office Salaries | | 36,919.29 | |
| Office E/B | | 11,075.79 | 30% |
| Office Supplies | | 3,900.00 | |
| Mgmt. Fee | .03 | 23,789.10 | |
| Med. Director | | 2,400.00 | |
| Training | | 900.00 | |
| Legal | | 1,200.00 | |
| Audit/Acctg. | | 5,000.00 | |
| Telephone | | 4,200.00 | |
| Advertising | | 600.00 | |
| Bad Debts | | 1,500.00 | |
| Misc. Adm. | | 900.00 | |
| Travel/Dues/Ed. | | 3,000.00 | |
| Total | | 95,384.18 | |
| **Plant Oper.** | | | |
| Electricity | | 15,000.00 | |
| Gas | | | |
| Water/Sewer | | 8,500.00 | |
| Exterm. | | 900.00 | |
| Refuse | | 1,800.00 | |
| Elev. Maint. | | N.A. | |
| Total | | 26,200.00 | |
| **Maint/Hskpg.** | | | |
| Maint. Sal. | | 39,779.24 | |
| Maint. E/B | | 11,933.77 | 30% |
| Supplies | | 11,400.00 | |
| Repairs | | 6,000.00 | |
| Purch. Serv. | | 6,000.00 | |
| Total | | 75,113.00 | |
| **Program and Trans** | | | |
| Prog. Dir. Sal. | | 11,439.78 | |
| Prog. Dir. E/B | | 3,431.93 | 30% |
| Van Ops. Exp. | | 1,200.00 | |
| Van Maint. | | 1,200.00 | |
| Supplies | | 1,200.00 | |
| Total | | 18,471.71 | |

## OPERATING BUDGET (continued)

| | Annual | Benefits |
|---|---|---|
| **Nursing** | | |
| Nsg. Sal. | 223,855.31 | |
| Nsg. E/B | 67,156.59 | 30% |
| Nsg. Supplies | 6,000.00 | |
| Pharmacy | 600.00 | |
| Total | 297,611.90 | |
| **Dietary** | | |
| Dietary Sal. | 50,439.03 | |
| Dietary E/B | 15,131.71 | 30% |
| Food .92 Per Meal | 48,909.04 | |
| Supplies | 8,575.92 | |
| Dietician | 2,400.00 | |
| Total | 125,455.70 | |
| **Financials** | | |
| Depreciation | 30,406.00 | |
| Interest @ 13% | 157,460.00 | |
| Prop. Ins. | 4,200.00 | |
| Vehicle Ins. | 1,800.00 | |
| Lic. Exp. | 250.00 | |
| Liability Ins. | 2,000.00 | |
| Bank Fees | 1,200.00 | |
| Total | 197,316.00 | |
| Total Operating Expenses | $835,553.20 | |

## INCOME PROJECTION

|  |  |
|---|---|
| 48 Semiprivate Beds<br>x 365 days = 17,520 days/year<br>x $45 = | $788,400.00 |
| 2 Private Rooms<br>x 365 days = 730 days/year<br>x $55 = | 40,150.00 |
| Total Revenue @ 100% Occupancy | $828,550.00 |
| Total Expenses | 835,553.20 |
| Net Income (Deficit) | $ (7,003.20) |

| Occupancy | Revenue | Projected Deficit |
|---|---|---|
| 95% | $787,123 | $48,430.20 |
| 90% | $745,695 | $82,855.00 |
| 85% | $718,904 | $109,646.00 |
| 80% | $676,615 | $151,935.00 |

This budget is based on a 100% occupancy rate which is extremely high. The facility has 24 semiprivate rooms for $45 per day and two private rooms for $55 a day. Rates are comparable to the Tucson and Phoenix area, but are higher than the $38.39 which Papagos are charged at Laveen. Total annual revenue generated by the hypothetical facility is $828,550; annual operating expenses are $835,553.20. Although the facility is operating at full capacity, it still shows an annual deficit of $7,003.20. Income at 95% occupancy would result in annual deficits of $48,430. At 80% occupancy, deficits would exceed $151,000 each year.

Although the true need for intermediate nursing home care among the Papagos is not known at this time, only 13 Papagos reside in an ICF. Occupancy projections for the tribe and anticipated revenues over the next five years are described below. The calculations do not include an inflation factor and it is assumed that costs and expenses will remain constant; revenues are based on semiprivate ($45/day) rates. First year occupancy rates assume all patients will be transferred to the reservation facility, which is unlikely since many have been institutionalized for several years.

OCCUPANCY AND BUDGET PROJECTIONS FOR
THE PAPAGO NURSING HOME

| Year of Operation | Number of Patients | Percent Occupancy | Annual Revenue | Anticipated Deficit | Cumulative Total Deficits |
|---|---|---|---|---|---|
| 1 | 13 | 26 | $213,525 | $632,274 | $632,274 |
| 2 | 25 | 50 | $410,625 | $435,144 | $1,067,418 |
| 3 | 30 | 60 | $492,750 | $353,019 | $1,420,437 |
| 4 | 35 | 70 | $574,875 | $270,924 | $1,691,361 |
| 5 | 40 | 80 | $657,000 | $188,769 | $1,880,130 |

At the end of five years, the projected budget deficit would total almost two million dollars which would necessitate supplemental financing by the tribe or from another income source.

The need to subsidize a nursing home on the reservation to prevent looming deficits was discussed with the administrator of the recently constructed Laguna Rainbow Indian Nursing Home and congregate housing facility in New Mexico. He revealed that although his budget was $726,000 this year, the tribe has already contributed an additional $327,000 to offset expenses. The Laguna Rainbow tribe has made a long term commitment to subsidize the new facility and Mr. Curley, the administrator, anticipates an increasing need for such support by the tribe as federal monies decrease.

According to the Assistant Director of Nursing at the Navajo Nursing Home in Chinle, even with high occupancy rates, their facility has continual budget problems. Compounding the Chinle facility's problems has been the Navajo Tribe's difficulty in receiving payment from the BIA for care rendered. The Navajo Tribe's Human Services Department does not receive enough money from the BIA to cover the cost of long term care.

The American Indian Nursing Home at Laveen which offers several levels of care, also has constant financial problems. In fact, according to a visiting Papago Tribe representative, the administrator stated that if a feasibility study had been conducted prior to construction, the home would probably not have been built.

## Staffing Considerations

All three American Indian Nursing Home administrators who were contacted to discuss aspects of operating a reservation facility considered staffing a major problem. Each facility has several vacancies which remain unfilled for long time periods. Two facilities complained about high turnover rates. Reasons given for this were: 1) Not many Indians find nursing home work satisfying. This is also a problem in anglo facilities. 2) There is a shortage of qualfied Indian nursing personnel although more are entering and graduating from nursing schools. 3) Most reservation nursing homes are in remote regions. therefore, traveling to the facility is time consuming and difficult, especially at night. 4) Nursing home salaries and benefits are not as good as at other health care facilities or with the IHS. One nursing home offering higher wages has been somewhat more successful at recruitment. Unfortunately, when wages and benefits increase, so does the budget deficit.

## Funding Sources for Long Term Care

In an era of diminishing resources and decreased government spending, prior to embarking on a costly project, it is important for the tribe to ascertain the commitment of the IHS and BIA to continue to support long term care. The IHS, once considered the primary source of payment for long term care, has recently become the agency of last resort. Long term care expenditures have escalated tremendously over the past 20 years straining the IHS health budget. According to an agency official, the IHS no longer wants financial responsibility for long term care, especially when alternate sources of payment such as the county are available. The IHS social work aide at Sells Hospital said that more than eight months had lapsed since the last new authorization for IHS nursing home payment.

Although the Papago Tribe Human Services Director feels the BIA will continue to honor its commitment to care for institutionalized Native Americans, the Navajo Nursing Home director in Chinle expressed frustration at the difficulty their institution has experienced in receiving adequate reimbursment. Mr. Curley, from the Laguna Rainbow Facility, is also pessimistic about the future commitment of federal agencies because of recent cutbacks in all social service programs. He anticipates even less support in future years. A spokesman from the National Indian Council on Aging suggested there was a trend toward decreasing financial involvement from both the IHS and the BIA.

Medicare will reimburse for 100 days of skilled nursing care, however, few elderly Papagos are eligible for benefits.

## Summary

The construction site, selected in Sells for the proposed reservation nursing home, is convenient to major health resources and is well located. Tucson architects have designed a floor plan for a 50-bed facility. Construction costs for the facility could be as low as one million dollars and as high as three million dollars depending on the final plans. In addition to construction and financing expenses, operating costs and revenues have been estimated for a five-year period. Conservative estimates suggest that there would be large budget deficits in a very short time. Almost two million dollars additional money might need to be generated by the tribe over the next five years to supplement patient revenues.

Since the BIA and the IHS are the primary payment sources for long term care, it is essential to determine future agency commitment to supporting institutional long term care. Federal agency officials and Indian nursing home administrators who were consulted are pessimistic about future support. Trends indicate that less and less money will be available in ensuing years.

The individuals contacted at three Indian nursing homes reported having continual budget problems. In addition, they expressed difficulty hiring and retaining qualified personnel; vacancies are common and turnover is high. Several reasons for this problem were discussed.

## Recommendations

At this time, the Center recommends that assurances be obtained to meet the anticipated budget before developing a reservation nursing home for the following reasons:

1. There are only 44 Papagos in institutions. This number includes skilled, intermediate, personal care and board and care patients.
2. Even a fully occupied 50-bed facility would not be cost-effective. In addition to construction expenditures, conservative estimates are that a two million dollar deficit would occur within five years of operation.
3. Hiring and retaining qualified staff for a facility on the reservation would be difficult due to the remoteness of the facility and the potential lack of qualified personnel.
4. There is uncertainty over continued funding for long term care from federal agencies. The IHS is more and more reluctant to pay for skilled care and some Indian nursing homes are having problems getting reimbursement from the BIA.
5. Institutional long term care is not preferred by most people. Quality of life is better if a person with impairments can remain in the community with family and friends.

Nursing home care is only one option in a continuum of services which can be provided in a variety of institutional and community settings. Long term care has been defined as the full range of services (diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance) to provide for those who have chronic mental and/or physical impairments. Its goal is to promote optimum health and functioning. The following recommendations are meant to provide the Papagos with suggestions for developing a more comprehensive long term care program.

The Center does recommend that the tribe conduct an in-depth community needs assessment to determine the true needs for long term care services. The completed survey should include age, type of impairment, long term care service need, support systems and the number of persons eligible for care. Results would be used to decide who would be appropriate for institutional or community care and would point the direction for the development of a comprehensive long term care program.

Estimates are that 75% of the elderly are seen at least once each year in a specialty clinic. It would be possible to develop an assessment tool and gather pertinent data about long term care needs of these elderly when they are seen in clinic.

The Center also recommends that the tribe consider implementing some or all of the following options to institutionalization which are often more appropriate and more affordable than care provided in a nursing home.

Option 1: Gain approval from the IHS to implement "swing" beds at the Sells acute care hospital. The swing bed concept, which has been evolving over the past ten years, is specifically for small (under 50 beds), underutilized (below 60%) hospitals similar to the Sells facility. Several projects in rural settings throughout the country have received federal approval and funding. These hospitals have been successful in improving hospital bed utilization and in providing skilled nursing care.

When a hospital has a swing bed unit, rather than discharging a patient from the acute care hospital to a skilled nursing home, patients are transferred to a previously unused hospital wing where nursing staff are now provided. Patients remain in the swing bed unit until their condition improves and they are discharged, or until their condition deteriorates and more intense care is required. Reimbursment for the swing bed is at the skilled nursing facility rate which is less than for an acute care bed, but far better than an idle bed which generates no revenue.

When contacted by the Center, the Tucson IHS director was very supportive of the swing bed concept. He had previously been in contact with Indian Health Service officials in Washington, D.C. and proposed that a project be implemented at Sells. No decisions have been made to this point. Again, there seems to be a reluctance on the part of the IHS to become more involved in long term care, although expenditures would be minimal.

## Advantages

In addition to the advantages discussed above, patients who are now transferred to a remote facility when in need of an SNF, would be able to remain on the reservation. Some of the 16 patients now in other facilities might also be returned to Sells.

## Disadvantages

The Indian Health Service would need to hire additional staff for the skilled care unit at the Sells facility. However, revenue from the swing beds would be retained at the hospital and would offset staffing expenditures.

Option 2: Start an adult day health (ADH) program on the reservation. According to a Tucson ADH program director who was contacted, there should be approximately one ADH program for every 500 elderly in the community. Minimum enrollment for each program should be no less than 20, nor more than 40. A community assessment would identify how many Papagos would be appropriate for a day care program. Centers are usually open six to eight hours a day, five days a week. However, most participants attend only two or three times a week. Although programs vary at each location, most include medical (rehabilitation) and social service (meals, recreation, occupational therapy) components. Eligibiity criteria include social, physical or mental impairments. The enrolled person may not be capable of living independently, but should have enough support so that he or she can continue to live in the community.

Advantages

By supporting and maintaining a person with impairments in the community, both family and patient benefit. A person with some impairments can still remain in the community with family and friends, yet benefit from a daytime supervised program. The family has a period of respite and relief for a few hours each week and the patient is able to participate in activities which help to maintain functional levels. Adult day care programs are known to help prevent premature institutionalization. Quality of life is usually greater for those able to remain out of an institution.

In addition, an ADH program is often less expensive than institutional care; a typical ADH program charges $15 a day; a personal care facility costs $20 to $30 per day. If the elderly program senior center or a congregate meal site could be utilized for the day care center, construction costs would be minimal. Renovations to widen doorways and to adapt bathrooms for the handicapped are much less than constructing a separate facility. Construction costs would be the Papago Tribe's responsibility.

Disadvantages

Constructing an adult day care center, although not so expensive as a nursing home would cost several hundred thousand dollars. Construction money from federal or state sources would be unlikely and the tribe would need to allocate funds or obtain financing for construction.

Transportation to and from the program could be a major obstacle, since the Papago Reservation is so large. Program costs could increase by as much as 100% if long distances are traveled when transporting ADH participants.

Although there is some money available from the Older Americans Act for program development, there is considerable competition for funds. Federal Title XX block grant monies for ADH payment have been severely cut. In fact, the Handmaker Jewish Geriatric Center which once had six ADH sites, has two remaining programs since federal support has declined. Again, the tribe would have to assume the burden of payment for developing and operating an adult day care program.

Option 3: Strengthen the current home care programs provided by the Wise Ones and the community health representatives (CHR). Most chronically ill people prefer living at home among family and friends rather than in an institution. The Wise Ones program now supports 30 to 40 chronically ill and impaired elderly persons by providing assistance with chores, homemaking and bathing. Funding, primarily from the Older Americans Act, is very limited. With little money for travel, only those living close to Sells are served. At present, the number with impairments in remote regions is unknown although workers who were interiewed say there are many who would benefit from an expanded program. According to the program director of the Wise Ones, the IHS has agreed to fund two home health aides this year which would increase service availability to some extent. An accurate needs assessment would determine how much to expand the program.

Although workers from the CHR program are expected to alternate responsibilities between transportation and home visiting every other week, home visiting often becomes a lower priority. Patients must be transported to various health facilities for clinic appointments, dialysis treatments and other health care needs. Additional staff would increase time spent in home visiting to all patients, including the elderly.

### Advantages

The primary advantage to expanding home care services is to support those who are chronically ill in the community: decreasing the risk of unnecessary institutionalization. Remaining at home with friends, family and familiar surroundings improves the quality of life for those who are chronically ill and home care is, in many cases, a cost-effective alternative to institutional care.

### Disadvantages

As with most community-based long term care programs, federal and state funding is insufficient. Medicare does not reimburse for long term home care; Title XX block grant money, specifically for the indigent, has been cut back severely and is very limited.

Option 4: Develop a skilled care home health care program. Home health programs providing skilled nursing care, physical therapy, occupational and speech therapy have expanded rapidly throughout the U.S. over the past few years. There are two home health agencies on the Navajo Reservation in Arizona providing skilled care. Tuba City's program has been operational since 1975; the Winslow program began in 1980. Although all tribe members are eligible, the program primarily serves the elderly. Both Navajo programs are integrated with the IHS Community Health Nursing programs at this time but are in the process of being incorporated into the tribal health program. Funding is currently from the IHS.

In addition to performing the regular duties which include assessment of babies, children, high risk obstetrical patients and persons with diabetes, the community health nurse carries a case load of patients requiring skilled nursing care.

Patients, identified by the hospital discharge planner, are referred to the home health program. Following a joint conference with the community health nurse and hospital staff, a home evaluation is made and service is begun. According to the Tuba City program director, patients with severe impairments have been able to remain at home with support from this program rather than being institutionalized.

## Advantages

The advantage of expanding home care and skilled home health have been described under Option 3.

## Disadvantages

As with other alternatives to institutionalization, there must be sufficient funding for a skilled home health care program to be viable.

If the program were Medicare certified, some revenue could be generated from patients qualifying for Medicare home health benefits. However, many elderly Papagos have not worked long enough to receive Medicare benefits.

The IHS representative from Tucson who was contacted stated that the agency could provide technical asistance if the tribe decided to develop a home health care agency, but no financial assistance for operational expenses would be available.

Staffing a reservation home health program might also be a problem. The program director at Tuba City has had two unfilled vacancies for quite some time. Qualified nurses are difficult to find. Many community health nurses, comfortable with preventative care, may not be trained to deliver skilled care.

The size of the reservation would also create considerable transportation costs. Due to the long distances which would be traveled between patients, mileage expenses would be high and the number of visits which could be made each day would be few.

Option 5: Develop an adult foster care program. Tribe members with impairments interfering with independent functioning may need a more sheltered environment. Yet these individuals do not belong in a nursing home. What they do require is a residence where meals, housekeeping services, some observation and personal care are provided. For a monthly stipend, selected families are willing to provide this support to individuals who need it. At this time, two Papagos are currently in private foster care residences off the reservation.

Advantages

Since the BIA allocates money to the Tribal Human Services Department for adult foster care, money is available to subsidize this program. In addition, the Tribal Human Services director is very supportive of the concept and would like to expand the program. Acording to her, several Papago families on the reservation would be willing to participate in the program.

A well-developed reservation foster care program would decrease the need to place those with impairments in personal care or board and care homes. Papagos in reservation foster homes would be able to practice traditional ways, eat familiar foods and would be able to remain with other tribe members.

Foster care is also a less expensive alternative to nursing home care. The BIA currently pays $14.70 a day ($447 a month) to the families with foster care residents in contrast to the $25 to $30 a day required for personal care.

Disadvantages

It would be important to provide adequate supervision for this program. Standards of care must be drafted and periodic home assessments would be necessary to ensure that foster home residents are not being neglected or abused.

**Concluding Remarks:**

The Arizona Long Term Care Gerontology Center hopes that you find this report beneficial in planning for the long term care needs of disabled and elderly Papagos. If any further help is needed to develop or expand current programs, we would be glad to assist in those endeavors.

Please contact us if you have any questions or if we may add to the content of this report.

# A Profile of American Indian Nursing Homes

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## Introduction

Life expectancy is increasing among all elderly Indians as it is among the Anglo population; and, it is well documented that as people age, the incidence of chronic illness and the need for long term care services (including institutionalization) also increases. Most Indians who require institutionalization must be placed in off-reservation facilities located far from home. These Anglo institutions rarely have staff who can communicate with their Indian residents; nor do they serve traditional foods or encourage the practice of traditional customs. Consequently, their Indian patients often experience social isolation and loneliness.

For these reasons, many Indian tribes are interested in constructing culturally-relevant, on-reservation nursing care facilities. There are currently eight nursing homes on reservation land and other tribes interested in exploring the possibility of future construction. Because of this, the Center determined that those who may be contemplating such a venture might benefit from the experiences of others currently operating Indian nursing homes. A questionnaire was developed and telephone interviews were conducted with administrators from each Indian nursing home throughout the country. This report summarizes data gathered during those interviews and presents a profile of each facility.

Literature on Indian nursing homes is virtually absent; consequently, this report adds significantly to the body of knowledge and, hopefully, serves as an impetus for future reports. However, this report cannot be considered a comprehensive statement about Indian long term care facilities since the information was gathered in an informal manner. Omissions or errors may be the result of asking the wrong questions or of inadvertently misinterpreting the information presented. Nevertheless, we hope this report will assist others to avoid pitfalls and to make informed decisions about long term care for elderly and disabled Indians.

## Existing Situation of the American Indian Elderly

### Demographics

According to the 1980 U.S. census, there are now more than 1.4 million American Indians, Alaskans and Aleuts belonging to more than 387 federally recognized tribes. Of that total, almost 75,000 are over the age of 65.[1] Furthermore, life expectancy is increasing among Indian people. Since 1950, life expectancy has increased by more than five years so that most Indians can now expect to live to at least age 65. Nevertheless, the life span of Indians is still eight years less than it is for their non-Indian counterparts and, while 5.3% of Indians reach age 65, more than 11.3% of the general population survives this long. [2,3]

### Health Status

The health status of the elderly Indian is significantly poorer than it is for other elderly people. Chronic illness is rampant, especially in rural Indians--about 50% of the total population. In fact, according to a study completed by the National Indian Council on Aging (NICOA) in 1981, impairment from chronic illness is as severe at age 45 for rural Indians as it is at age 65 for non-Indians.[4] Major health problems include obesity, diabetes, hypertension, circulatory and respiratory disorders and visual problems.[5] In some tribes, certain chronic illnesses are even more common than they are in other tribes. For example, although diabetes is common among all Indian tribes, according to the 1981-84 Tribal Health Plan of the Papago tribe of Arizona, 50% suffer from diabetes by the time they are 45 years old.[6]

### Socioeconomic Status

Poor health is only one of many problems faced by Indian elderly in this country. More than 61% of those over 65 have incomes below the poverty level. In other words, most elderly Indians existed on less than $3500.00 in 1980.[7] In contrast, only 25% of the total U.S. population is that poor. Reasons for this discrepancy are numerous and include the fact that unemployment is extremely high among Indians-ranging from 38% on some reservations to 95% on others.[8] In addition, few elderly Indians work long enough to collect social security benefits; and those who have worked, often had jobs with companies not participating in the social security program. Although Indians are eligible for federal aid such as Supplemental Security Income, many often do not receive all available benefits. A lack of knowledge about available programs and a failure to complete the paperwork required to initiate the benefit process are two reasons why many fail to receive aid for which they qualify.

## Cultural Trends

Cultural changes among tribe members have negatively affected the elderly Indian. Many of the younger generation no longer respect and revere the elderly as they once did. Instead, they have adopted attitudes similar to the dominant Anglo culture and tend to spend less time and give less attention to their older parents and grandparents. Although Indians continue to be part of a large extended family, this network can no longer always be depended on for support. Stories of neglect, rarely mentioned in the past, have surfaced in recent years.[9] One explanation for this breakdown in tradition is the high incidence of alcohol consumption among middle aged and younger family members. In addition to spending the limited resources of the old people, those who are dependant on alcohol sometimes neglect the person with impairments leaving them alone for days at a time.

In addition, although most families continue to have strong ties with their elderly parents and grandparents, economic realities have forced younger tribe members to look for off-reservation work. Consequently, the elderly must fend for themselves during the day when other family members are working.

## Health Care of the Elderly Indian

Conflict between Congress and individual state and local governments often arises when discussing whose responsibility it is to provide health care for Indians. Each level of government has a different point of view. State and local governments consider the IHS to be the primary provider of health care and may not take responsibility for the care of sick Indians. In contrast, the federal government views the IHS as a supplementary program and encourages the states to assume major health care responsibilities for their Indian citizens. Caught between two conflicting philosophies and policies, it is the Indian who suffers the consequences.

The usual method by which elderly Indians receive acute and primary health care is through the Indian Health Service (IHS). The IHS, a unit under the U.S. Public Health Service, assumed this responsibility from the Bureau of Indian Affairs (BIA) in 1955. Most people incorrectly assume that all Indians are eligible to receive health care services from this federal agency. However, the IHS primarily serves the rural Indian; urban Indians (about half of the population) must seek other health care facilities such as urban hospitals and clinics to meet their health care needs. Since this is a costly alternative, most urban Indians only seek help in emergency situations. In fact, there is little evidence in the literature demonstrating the existance of prevention and health maintenance programs for adult and elderly Indians.

The IHS, with service units throughout the country, provides a variety of health care services. Although not all IHS hospitals are fully equipped, many provide acute hospital care, ambulatory clinics and community health nursing services. If the IHS does not have complete on-reservation facilities and staff, contracts to provide the needed care are established with appropriate community health care facilities. For example, the IHS hospital in Sells, Arizona does not perform surgery and sends all surgical patients to Tucson, Arizona.

## Status of Long Term Care for the Elderly Indian

Long Term Care has been defined as those services designed to provide diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and non-institutional health settings including the home, with the goal of promoting the optimum level of physical, social and psychological functioning.[10] As life expectancy increases, so does the incidence of chronic illness. Concommitantly, a higher incidence of chronic illness results in a greater need for long term care services.

Because most programs are underfunded and lack sufficient resources to provide the level of care needed, the existing long term care system for the elderly Indian in no way satisfies their need for service. Community long term care support for elderly Indians occurs primarily through the IHS Community Health Nursing programs, tribal community health programs, and homemaker-home health aide services sponsored by the Older Americans Act. A few tribes have developed home health agencies to care for those with more skilled nursing needs.

Although most Indian tribes attempt to support their elderly in the home, this is not always feasible. As life expectancy has increased, so has the incidence of chronic illness and some tribe members have developed mental and physical impairments too severe to be managed at home. As mentioned earlier, cultural attitude changes in the younger generation has resulted in fewer community and social supports even for those who might remain in the community. Consequently, the need for institutional placement is increasing.

Placement in non-Indian nursing homes has created many problems for the institutionalized person and for his or her family members. Most non-Indian homes are located far from reservation land and since most elderly Indians are too poor to own cars or to pay for transportation, vists from family and friends are infrequent. As a result, those requiring institutional care are often lonely, depressed and isolated.

Furthermore, few non-Indian facilities are culturally sensitive to the needs of their Indian residents, many who may not even speak English. The residents are often surrounded by Anglo patients and cared for by Anglo employees. The Indian patient often has an extended family who may wish to spend long hours at the patient's bedside. Anglo workers, often unresponsive to the needs of the patient and his family may insist that institution rules be maintained. This conflict between family and employees can lead to hostility and discord creating an uncomfortable situation for the Indian patient. Family and friends may desire to have "Sings" at the patient's bedside or may request the services of a medicine man. However, many customs are misunderstood by nursing home employees and ritual practices may result in discord and strain between staff and family members.

As a result, most Indian tribes would prefer to construct nursing homes on reservation land and to staff the facility with Indians from their own tribe. This recommendation, first submitted to the 1971 White House Conference on Aging, was again presented to representatives of the First National Indian Conference on Aging in 1975. In 1978, the urgent need for additional reservation facilities was again a topic of discussion at the Second National Indian Conference on Aging. The first Indian nursing home was built in 1969 and six others were constructed in the 70's. Consequently Indians are approximately ten to fifteen years behind non-Indians who began extensive nursing home construction in the 1960's. Although there are approximately 4600 Indian residents in non-Indian nursing homes, there are only eight reservation homes with approximately 410 residents.[11]

## Long Term Care Financing for Indians

As a consequence of the Snyder Act of 1921, the U.S. government has a trust responsibility to American Indians which includes providing adequate health care services. In 1976, when the Indian Health Care Improvement Act (PL 94-437) was enacted, Medicaid and Medicare funds became available to tribally-operated facilities. As a result, in all states but Arizona (which did not participate in the federal Medicaid program until recently), nursing home payment for Indians occurs through the federal Medicaid program. Medicare reimbursement is available to those meeting the criteria; however, since most Indians have not worked long enough to qualify, few are eligible.

In 1982, because county and state resources were being depleted, the Arizona legislature agreed to participate in a three year Medicaid demonstration project with the Health Care Financing Administration. The project, a prepaid, capitated HMO-type demonstration, presently does not provide for long term care payment. Therefore, indigent long term care payment remains the responsibility of the individual counties. Indian patients requiring institutional care are, theoretically, the responsibility of the county in which they reside. According to a Pima County case manager few Indians now receive county long term care funding.

In Arizona, if the county does not assume payment for the Indian long term care patient with skilled needs, it becomes the responsibility of the IHS. Once considered the agency of first choice for long term care payment, the IHS has experienced severe budget cuts in recent years and has become the agency of last resort. Unfortunately, some Indian patients have remained in IHS acute care facilities for as long as a year waiting for IHS transfer approval to a long term care facility. Institutional care classified as "less than skilled" is financed by the BIA in Arizona. Indian nursing home administrators who were polled state that the BIA is often slow to reimburse for services and does not allot a satisfactory rate.

## Characteristics of Indian Nursing Homes

There are currently eight nursing homes located on reservation land in five states. These facilities serve several different Indian tribes. The oldest facility (American Indian Nursing Home, Laveen, Arizona) was built in 1969; the youngest facility (Laguna-Rainbow, New Laguna, New Mexico) has been operational since 1982. The nursing homes range in size from 20 beds to 96 beds and their combined patient capacity is 410. Although some facilities offer only one level of care, others admit patients with skilled, intermediate, personal and board and care needs.

Most facilities maintain high occupancy levels (90-100%) and several have waiting lists. However, two of the homes (Blackfeet-Shelby, Montana; Carl T. Curtis-Macy, Nebraska) have lower occupancy rates which the administrators attribute to the high use of home health agencies located nearby. Apparently, these home health agencies have been successful at delaying institutionalization of many elderly Indians.

Table 1 lists the year each Indian facility began accepting patients, bed capacities, levels of care offered and occupancy rates. Table 2 lists the states in which the facilities are located and the tribes primarily served. (Appendix A includes the complete name of each facility and its state location)

Table 1

Indian Nursing Homes, Starting Dates, Bed Capacity, Levels of Care, Percent of Occupancy

| Date | Facility | No. of Beds | Levels of Care | % of Occupancy |
|---|---|---|---|---|
| 1969 | American Indian | 96 | Skilled; Intermediate<br>Personal Care<br>Board and Care | 100% |
| 1971 | Chinle | 79 | Skilled | not answered |
| 1974 | Blackfeet | 49 | Skilled; Intermediate | 69-70% |
| 1978 | Oneida | 50 | Skilled; Intermediate<br>Personal, Board and Care | 90-92% |
| 1978 | Toyei | 66 | Personal | 90-100% |
| 1978 | Carl T. Curtis | 25 | Intermediate | 80-85% |
| 1979 | White River | 20 | Personal Care | 90% (winter) |
| 1982 | Laguna-Rainbow | 25 | Intermediate | 100% |
|  | Total | 410 |  |  |

Table 2

State Location of Indian Nursing Homes and Tribes Primarily Served

| No. of Facilities | State Location | Tribes Served |
|---|---|---|
| 4 | Arizona | Papago, Pima<br>Navajo, Apache |
| 1 | Montana | Blackfeet |
| 1 | New Mexico | Laguna |
| 1 | Nebraska | Omaha |
| 1 | Wisconsin | Oneida |
| Total 8 |  |  |

Number of Staff and Percentage Who are Indian

Table 3 illustrates the percentage of nursing home staff who are Indian. Six facilities employ from 80 to 100% Indian staff. The Oneida facility, located on a small reservation in a densely populated area of Wisconsin, has the lowest number of Indian employees and the highest number of non-Indian patients (10). In contrast, the White River Group Home employs 100% White River Apaches.

Table 3

Percent of Indian Staff at Each Facility

| Facility | % Indian Staff |
|---|---|
| American Indian | 83 |
| Blackfeet | 94 |
| Carl T. Curtis | 80 |
| Chinle | not answered |
| Laguna-Rainbow | 95 |
| Oneida | 71 |
| Toyei | 91 |
| White River | 100 |

Patient Admission Criteria

Although four long term care facilities are strictly limited to Indian patients, three others have open admission criteria. Of those three, two currently have non-Indian patients. Originally these facilities limited their admissions to Indians; however, in order to boost occupancy rates, non-Indians have been admitted in recent years.

Table 4

Admission Criteria; Number of Non-Indian Patients

| Facility | Admission Criteria | No. of Non-Indians |
|---|---|---|
| American Indian | open | 0 |
| Blackfeet | open | 3 |
| Carl T. Curtis | 1) Omaha Indians<br>2) Other tribes | N.A. |
| Chinle | not answered | not answered |
| Laguna-Rainbow | 1) Laguna Indian<br>2) Other Indian | N.A. |
| Oneida | 1) Adults only | 10 |
| Toyei | Reservation Indians | N.A. |
| White River | Reservation Indians | N.A. |

## Financing for Capital Construction

The urgent need for more long term care facilities on Indian land has been recognized by Indian leaders for more than a decade. Yet, few homes have been constructed. There are several explanations for this; but, certainly one problem has been the lack of financing. In 1975, the Health Facilities Act (PL85-151) was enacted. It provided assistance to public and non-profit agencies or organizations to construct hospitals designed to meet Indian health care needs if this proved more effective than constructing federal government health facilities. However, wording of this act excluded long term care facilities.

In addition to paying for institutional skilled long term care, the IHS will provide technical assistance to tribes who construct on-reservation nursing homes. However, its budget does not include monies for facility construction. This is also true of the BIA. Currently, the Bureau continues to be responsible for long term care payment (in Arizona) if the care is classified as less than skilled, but, funds are not to be used for constructing facilities.

Two reservation homes, (Oneida, Chinle) received Hill-Burton money to assist with construction. Hill-Burton funds were made available through Title VI; Section 609 of the Public Health Service Act. The bill's name is derived from the two senators who sponsored it originally. Beginning in 1947, grants for up to 50% of construction costs were made available to hospitals in order to construct new facilities or to significantly remodel outmoded ones. The original formula was initially weighted in favor of rural hospitals. Hill-Burton was subsequently extended to include nursing homes, rehabilitation centers and ambulatory care centers. When there became too many beds for the number of available patients, Hill-Burton funds were terminated. This occurred in the late 1970's.

Carl T. Curtis Health Education Center and Nursing Home received a federal appropriation (the source of the appropriation is unknown) to construct its nursing home and entire health center including a home health agency, ambulatory care clinic, ambulance service, dental care facility, social services department, mental health and health education program.

The American Indian Nursing Home, owned and operated by the American Indian Church,was built with church donations. According to the current administrator, the two ministers who founded the facility were adept at fund raising. The Laguna-Rainbow Facility, the most recent home to be built, was constructed with allocated tribal money, as was the Blackfeet home in Montana. In Ganado, Arizona, an old boarding school was renovated with voluntary labor and building supplies provided by the BIA. It is now known as the Toyei Personal Care Facility. The White River Apache Tribe houses its clients in two, five bedroom reservation homes but authorities expect to receive H.U.D. funds for constructing a new facility some time this year.

Table 5

Capital Financing of Each Facility

| Facility | Capital Financing |
|---|---|
| American Indian | Donations |
| Blackfeet | Tribal Resources |
| Carl T. Curtis | Federal Appropriation |
| Chinle | Hill-Burton |
| Laguna-Rainbow | Tribal Resources |
| Oneida | Hill-Burton; Tribal Resources |
| Toyei | Labor—volunteer; Supplies BIA |
| White River | Tribal Resources |

## Licensing and Regulation of On-reservation Homes

The federal government's power over Indian tribes, including its legislative authority, is constitutionally derived and unless there are special circumstances or contrary federal statutes, regulation of on-reservation nursing homes remains the federal government's responsibility. In other words, states generally do not have the power to directly regulate on-reservation facilities when these facilities primarily serve Indian clients. However, there are circumstances when individual state laws pre-empt federal authority. For example, if a tribe applies for a federal grant to construct a health care facility, compliance with state and local zoning and building requirements may be necessary. In addition, if a tribe wishes to receive the maximum financial assistance available from the federal government, compliance with state standards may be required before funds are allocated. The Indian Health Care Improvement Act (PL94-437), in 1976, made Medicaid and Medicare funds available to tribally operated IHS facilities if the facility complied with standards established for other Medicare and Medicaid recipients. Consequently, Indian nursing homes in states receiving Medicaid or Medicare funds must obtain state licensing before payments are received.

All but two of the on-reservation nursing homes have licensure from the states in which they are located. The White River Apache Tribe has not applied for state licensure since its primary source of revenue is the BIA and certification is unnecessary. The personal care facility in Toyei would like to become state certified. However, the facility, located in a renovated boarding school, does not meet Arizona health facility building code standards. Since upgrading the current building would require considerable renovation and expense, plans are being made to raise money to construct a home to meet Arizona codes.

None of the facilities are Medicare certified. In fact, most of the administrators are reluctant to certify their facilities since so few Indian patients are eligible. In addition, the facility which provides Medicare beds must set these beds aside for use only with Medicare patients. This can lead to a loss of revenue and since requirements for Medicare certification are stringent, most facilities would spend an inordinate amount of time and money on renovation projects with little financial remuneration.

Table 6

Federal and State Licensure

| Facility | Licensing Agencies | Level of Licensure |
|---|---|---|
| All Indian | Az. Dept. of Health Services<br>Gila River Indian Tribal Association | Skilled, Intermediate, Personal, Board and Care |
| Blackfeet | Montana Dept. of Health and Environmental Services | Skilled; Intermediate |
| Carl T. Curtis | Nebraska Department of Health | Intermediate |
| Chinle | Az. Dept. of Health Services<br>Joint Commission Accreditation of Hospitals (JCAH)<br>IHS Environmental Health Facility | Skilled |
| Laguna Rainbow | New Mexico Dept. of Human Services | Intermediate |
| Oneida | Wisconsin Division of Health and Social Services | Skilled, Intermediate, Personal, Board and Care |
| Toyei | IHS Environmental Health Facility | Personal |
| White River | --- | Personal |

## Incorporation of Cultural Architecture, Customs and Language

The need for culturally relevant on-reservation nursing homes has been discussed since 1971. These facilities should, according to Indian leaders, incorporate tribal architecture, cultural foods and traditional customs. However, except for the Chinle facility, the Indian nursing homes resemble Anglo institutions. The Chinle facility is the shape of a hogan, a hexagonal building used by the Navajos for residence and for ceremonial purposes. The door faces east according to Navajo custom. Parenthetically, the most recently constructed facility (Laguna-Rainbow) which serves pueblo Indians was designed by Anglo architects and does not include pueblo designs. Hence, it is not in keeping with the rest of the New Mexico landscape.

All of the nursing homes permit patients and families to practice traditional customs if they wish to do so. The Omaha tribe no longer has its own medicine man and must borrow one from another tribe when necessary. Administrators stated they permitted families to do ritual "burnings," participate in "sings" and smoke the peace pipe. Although most institutions do not have special rooms for tribal customs and native medicine practices, day rooms and outside ramadas are reserved for Indian dancers and other traditions. Traditional Indian food, often high in salt and fat, is not always nutritious or well balanced and since most facilities must conform to state standards, it is not feasible to serve these foods more often than once a week.

Since most long term care facilities on reservations are staffed by native Americans, patients are able to speak their own language which alleviates the isolation and loneliness experienced by those in non-Indian homes. In fact, all administrators stated that a strength in their programs included the dedicated Indian staff able to communicate fluently with patients, and the cultural programs for the institutionalized elderly. Many of these nursing homes may be struggling in several ways, but they apparently give excellent care to elderly Indians. In fact, following admission, it is not uncommon to see significant health improvements in patients who were once quite debilitated.

## Programs and Services Offered

There is variability in the number and kind of services offered at the various on-reservation nursing homes. Each facility differs in the type of patient admitted to its program and in the level of care offered. Most facilities provide occupational, physical and recreational (activity) therapy services. Personnel providing these treatment modalities may be full-time or part-time staff or may be independent contractors. In some cases, therapists are responsible for patients in the nursing home and in ambulatory care and home health. If the facility does not have the services described above, arrangements are made to transport patients to treatment centers.

There are no day care centers attached to reservation nursing homes, although one is planned for the Laguna Rainbow facility. Laguna Rainbow, which has a congregate home, also provides congregate meals for other elderly Indians. The congregate meal program is financed with Older Americans Act funds.

## Proximity to Acute Care Facilities

Some Indian nursing homes are very close to acute care facilities, others must take their patients over 50 miles away for treatment. For example, the Blackfeet home is four blocks from the nearest IHS facility. In contrast, acutely ill patients at the Toyei facility must travel 65 miles to the east to reach the IHS facility in its region. Ironically, the nearest IHS facility is only 26 miles away at Keams Canyon, but it is located in a different region.

Needless to say, this has created unnecessary and even dangerous hardships on patients. Table 7 lists each facility and its proximity to the nearest available hospital.

Table 7

Proximity of Indian Nursing Homes to Acute Care Facilities

| Facility | Nearest Acute Care Facility |
|---|---|
| American Indian | IHS, Phoenix, 16 miles |
| Blackfeet | IHS, 4 blocks |
| Carl T. Curtis | 30 miles (Small IHS hospital, 10 miles.) |
| Chinle | not answered |
| Laguna-Rainbow | IHS hospital, 4 miles |
| Oneida | 10 miles |
| Toyei | IHS in region 65 miles; IHS not in region, 26 miles |
| White River | For one home, 5 miles; for second home, 52 miles |

## Comparison of Indian Nursing Home Residents to the General Nursing Home Population

### Ratio of Male to Female Patients

In the non-Indian nursing home population, female residents outnumber males by approximately three to one. This is essentially because women live approximately seven years longer than men and it is well documented that the need for institutionalization increases with age due to the increased incidence of severe chronic illness resulting in functional impairments. Among Indians, women also live longer than men by 10½ years.[12] Therefore, one might expect Indian nursing home statistics to follow patterns of the general population. However, there are discrepancies in several instances. In two homes (American Indian, Laguna-Rainbow), male patients outnumber females by more than two to one. In another two facilities (Carl T. Curtis, Toyei), there are as many male patients as there are female patients. In the remaining three facilities from which data were obtainable, approximately 60% of the patients are female; the remaining 40% are male. In fact, none of the Indian facilities had as many female patients as are found in non-Indian homes. (See Table 8)

Explanations for this striking departure from the total U.S. population includes the fact that crippling automobile accidents occur with relative frequency on reservation land. Many of these accidents involve men and are alcohol-related. Cumulative effects of chronic alcoholism in men leading to functional impairment also accounts for the higher number of male Indian nursing home admissions in some facilities.

### Table 8

### Ratio of Male to Female Patients

| Facility | Ratio of Male to Female |
|---|---|
| American Indian | 2:1 |
| Blackfeet | 1:2 |
| Carl T. Curtis | 1:1 |
| Chinle | not answered |
| Laguna-Rainbow | 2.3:1 |
| Oneida | 1:1.3 |
| Toyei | 1:1 |
| White River | 1:1.5 |

## Average Age of Patients

The average age of persons institutionalized in the U.S. is 82. In contrast, the Indian nursing home population in two facilities is only 65 years (Curtis T. Cook) and 66.2 years (American Indian). Both Administrators stated they have many younger patients ranging in age from 35 to 55 years. High rates of alcohol abuse and serious automobile accidents are again implicated as major reasons for the younger patient population.

### Table 9

### Average Age of Patients

| Facility | Average Patient Age |
|---|---|
| American Indian | 66.2 |
| Blackfeet | 72 |
| Carl T. Curtis | 60-70 |
| Chinle | not answered |
| Laguna-Rainbow | 82 |
| Oneida | 83 |
| Toyei | 82 |
| White River | 75 |

## Benefits and Salaries Compared to Urban Nursing Homes

The nursing home industry does not pay well, nor is it known for providing a comprehensive benefit package to its employees. Most personnel are paid less than those who work at hospitals or other health care facilities. Consequently, it is often difficult to find and retain qualified professional and non-professional staff. Turnover is high and positions frequently remain unfilled for long time periods. Since most on-reservation Indian nursing homes are located in remote regions, questions were asked to determine whether Indian facilities would compensate for this by paying higher wages and offering better benefits than their urban counterparts.

In fact, two facilities (Laguna-Rainbow and Carl T. Curtis) do offer better benefits and salaries than nearby urban facilities. In addition to higher wages, both facilities offer paid health insurance, sick leave, holiday time and annual vacation time. Retirement plans, often not available to urban nursing home employees, are a benefit offered both at Laguna-Rainbow and Carl T. Curtis.

Three other homes (Toyei, Oneida, Blackfeet) have wage and benefit packages comparable to nearby urban nursing homes. One (Toyei) offers a retirement plan; the others do not. The Blackfeet Home in Montana, does not offer health insurance to its employees.

Unfortunately, the American Indian Nursing Home (Laveen, Arizona), which is plagued by high employee turnover and absenteeism, has lower salaries than urban facilities and offers few benefits to its staff. For example, the home has no retirement program, no paid sick time (except for exempt employees) and no health insurance benefits. Like many other Indian nursing homes, the Laveen facility has fiscal difficulties and since most employees are Indian and eligible for IHS health care, the administrator felt costs would be minimized by not offering a health insurance package.

The administrator of the White River facility did not know how his salaries and benefits compared with urban board and care homes. However, he did state that its wage and benefit package was comparable to other tribal reservation programs.

Although it was not possible to interview the Chinle administrator, others acquainted with this skilled nursing facility felt that it offered higher wages to professionals and even paid transportation costs for nurses living out of state, who were willing to relocate. Chinle is in an extremely remote section of the 14 million acre Navajo reservation.

Table 10

Wage and Benefits Offered at Indian Nursing Homes; Comparability to Nearby Urban Facilities

| Facility | Wage and Benefit Package |
|---|---|
| American Indian | Lower salaries than urban; 7 paid holidays; 2 week paid vacation; no paid sick time; no health insurance, no retirement benefits |
| Blackfeet | Comparable salaries with urban homes; sick leave; vacation; no retirement program; no health insurance benefits |
| Carl T. Curtis | Slightly higher salaries than urban; paid vacation; paid sick time; paid holidays; health insurance benefits, retirement program |
| Chinle | not answered |
| Laguna-Rainbow | Higher salaries than urban; paid vacation; paid holidays; paid sick time; retirement program; health and life insurance benefits |
| Oneida | Salaries comparable to urban; vacation; paid holidays; life insurance; disability insurance (long and short term); paid sick time; dental plan; education benefits; no retirement program |
| Toyei | Salaries comparable to urban; paid vacation; paid sick time; medical insurance; retirement plan |
| White River | unknown |

## Common Diagnoses and Reasons for Nursing Home Admission

According to a 1977 nursing home survey,[13] patients admitted to U.S. nursing homes most commonly suffer from the three chronic illnesses listed below:

1. Arteriosclerosis
2. Heart Trouble
3. Senility

The most frequently cited explanation for institutionalization is cognitive impairment (confusion) which interferes with independant functioning. In fact, more than 56% of all nursing home residents suffer from moderate to severe cognitive impairment.

In contrast, the incidence of cognitive impairment among Indian nursing home residents is relatively low. More commonly, patients are admitted because of severe physical impairment from illnesses prevalent in the total Indian population. The three most common diagnoses are:

1. Diabetes Mellitus
2. Alcohol Abuse
3. Stroke

Long standing diabetes results in circulatory (heart and blood vessel) problems, amputations, blindness and kidney failure. Alcohol abuse can lead to liver and brain damage. Stroke often results in paralysis of part of the body.

## Major Problems Encountered By Indian Nursing Home Administrators

### Financing

All eight nursing home administrators stated their primary concern was obtaining and maintaining adequate financial resources. Although only one administrator (Blackfeet) actually reported a current deficit, several others receive sufficient tribal support to prevent negative cash flow. The problem of an inadequate supply of money for daily operations was repeated over and over. Most administrators said the only method enabling them to meet the budget is severe expense cutting. Some have not increased expense budgets for several years, although prices have escalated dramatically. Other institutions have not approved employee salary increases in two or more years.

In Arizona, the BIA reimbursement rate and its mechanism for payment creates an additional hardship for Indian nursing homes. Homes dependent on the BIA for payment find it difficult to negotiate adequate rate increases. Financial problems are compounded because the BIA does not pay prospectively for services rendered. Instead, billing occurs ex post facto. Therefore, patients are cared for and payrolls are disbursed before money is received from the government.

### Staffing

An additional problem which plagues several administrators is an inability to hire and retain professional staff. There are few Indians who are professional nurses and they seem to prefer acute hospital work and community health work. Some who are employed by the IHS are unwilling to relinquish secure jobs with good benefits and salaries to work for tribal programs whose benefits cannot compete.

Hiring and retaining non-professional Indian nursing home staff is frequently difficult. Aides and orderlies often have problems with alcohol and may be undependable as a result. Cultural differences also interfere with employee attendance records; absenteeism at some homes is common on payday and during fiesta time. Some administrators have been forced to adopt strict personnel policies to eliminate both absenteeism and tardiness. For example, at one facility, if a worker is absent one time, he or she is suspended; the second absence is grounds for termination. Some disgruntled employees seek redress with the tribal council after employment termination and if the administrator does not have ultimate authority for hiring and firing, he may be unable to stand firm without risking his own job.

## Summary

This study was conducted to develop a profile of Indian nursing homes throughout the country for use by Indian tribes who may be planning to construct their own facility. A questionnaire was devised and administrators of Indian nursing homes were interviewed by telephone. Data collected during the interviews and from discussions with IHS and BIA officials revealed that although Indian nursing homes are similar to non-Indian nursing homes in many respects, there are also significant differences. For example, many of the eight Indian homes have a higher ratio of male patients than in the general nursing home population. In addition, the average age of patients in the Indian facilities is frequently lower than it is in Anglo facilities. Also, most homes are located in remote regions distant from acute care facilities in contrast to non-Indian homes which are usually located in urban areas.

All facility administrators who were polled considered the lack of adequate financial resources to be the major problem in program administration. Unlike Anglo long term care institutions, Indian nursing homes rarely have a patient mix consisting of private and publicly supported patients. Institutionalized Indians are usually very poor. Medicaid resources are the payment mechanism for facilities not in Arizona. Indian nursing homes in Arizona differ since they receive payment for long term care from the BIA and the IHS.

Although many nursing homes in the general population have staffing difficulties, several of the Indian facilities have even greater staff problems. There are few qualified Indian professionals trained in long term care so that administrators and nursing home directors are often Anglo. Those who are Indian sometimes lack appropriate education. Absenteeism and turnover among nonprofessional staff is high in several homes and interferes with facility operations.

Finally, according to information gathered during the telephone interviews, the most positive aspects of culturally specific nursing homes is that institutionalized elderly Indians remain closer to family and friends; can communicate in their own language and are able to practice traditional customs, if desired. In many cases, institutionalization has resulted in an improvement in health status.

## Implications For The Study

Data gathered during this survey raises several implications for those who serve the elderly with long term care needs. These implications are listed below:

1. There is a need for capital financing for nursing home construction on reservation land. Although two Indian nursing homes were partially constructed with Hill-Burton monies, these funds have been terminated because of the overabundance of urban hospital and nursing home beds. Consequently, there are currently no federal programs available to assist Indian tribes with capital financing. Congress might consider reinstating the Hill-Burton program specifically to meet the needs of Indian tribes.

2. Construction of centrally located regional Indian nursing homes serving several tribes should be encouraged. This would be cost-effective since most tribes are unable to finance individual facilities or do not have a sufficient number of nursing home residents to justify building their own reservation nursing home. However, prior to initiating an inter-tribal nursing home project, there must be agreement on several issues such as: where the facility will be located, which tribe or tribes will assume primary management responsibilities and how various tribal customs and languages will be supported.

3. University programs preparing long term care administrators should be encouraged to enroll Indian students interested in pursuing such a career. Financial assistance for these students might be possible from scholarships, traineeships or low interest loans. The money for such programs might be provided by tribes and by federal agencies concerned with improving the health status of Indians.

4. Schools of nursing should be encouraged to enroll and train Indian students demonstrating an interest in geriatric nursing. Once graduated, these nurses can return to the reservation and serve as role models in Indian nursing homes. Tribes would also benefit if Indian nurses currently working with the elderly had opportunities for further education. Since many nursing programs now sponsor geriatric nurse practitioner programs and advanced degrees in gerontological nursing, these programs should solicit the enrollment of Indian students. Again, scholarships and traineeships would ensure greater program participation.

5. Staff development programs to train male attendants to work in Indian nursing homes should be developed. The preponderance of male patients in many Indian facilities results in the need for a higher ratio of male attendants. At present, there is a dearth of qualified and interested male Indians serving in this capacity.

6. Programs to increase the cultural sensitivity of staff who work with Indian residents in Anglo nursing homes should be instituted. Many of the more than 4000 Indian residents in non-Indian nursing homes currently experience feelings of social isolation and depression compounded by the insensitivity of Anglo staff members. In what way might the American Association of Homes for the Aged and the American Health Care Facilities Association positively influence Anglo facilities to develop such programs?

7. Prevention and health promotion programs should be promoted for the middle aged and older Indian. Although there are currently programs for young children which stress health promotion and prevention strategies, these programs should be expanded to include older Indians. A person may discover diabetes mellitus at age 45; however with proper nutrition, exercise and lifestyle modifications, complications such as blindness, kidney failure and/or amputation may be prevented or delayed. Adults also serve as role models for children and their behavior can reinforce positive health habits in the young.

8. Greater efforts at identifying and treating the causes of alcoholism in Indians should take place. Alcoholism continues to be a severe problem among middle aged Indians and contributes to staffing problems in nursing homes and to the eventual need for long term care placement of certain individuals.

9. Reimbursement for long term care by the BIA, IHS and Medicaid must be increased. Because current payment for long term care is so low, most of the facilities experience budget deficits which are kept to a minimum by tribal subsidies. Most reservation facilities are located in remote areas where utility rates, transportation costs, staff salaries and fuel expenditures are higher than for urban nursing homes. Some urban hospitals predominantly serving low-income patients are now reimbursed by Medicaid at higher rates; the federal government should consider a similar program for Indian tribes. Another solution might be to develop a separate Medicaid program for Indians.

10. The role and responsibilites of the BIA and the IHS should be reaffirmed. Recent cutbacks in federal social service programming has resulted in less money for these agencies. Discussions with IHS officials revealed that while some officials may wish to continue to support payment for long term care, others want to discontinue the program since it represents such a drain on resources. Since the federal government has a trust responsibility to American Indians which includes providing health care to those who need it, these discrepancies should be clarified.

11. Indian tribes should be encouraged to develop a comprehensive long term care system. The current Indian long term care system is fragmented, incomplete and institutionally biased. There are few day care centers, home health agencies or congregate living quarters on reservation land. Although the Older Americans Act has provided money to tribes for meals and home care services, this program has been underfunded and demands exceed the budget allocations. In 1981, the Omnibus Reconciliation Act was passed. Until then, Medicaid payments for long term care were primarily for institutional care. However, the 1981 Act, under the Section 2176 Home and Community Based Waiver Program allows states to pay for services such as case management, homemaker home health aides, respite and other community based options which prevent or delay institutionalization. Perhaps Congress could be encouraged to support a similar measure for Indians. The Health Care Financing Administration might be approached to provide demonstration monies to tribes in several regions. Technical assistance for program development could be the responsibility of the IHS and of federally supported long term care gerontology centers.

## FOOTNOTES

1. U.S. Bureau of the Census, 1980, p.3

2. Ibid, p.3

3. Ibid, p.3

4. *American Indian Elderly: A National Profile*, Nationul Indian Council on Aging, 1981, p.3

5. *The American Indian and Alaskan Indian*, Technical report to the White House Conference on Aging, 1981, p.3

6. *American Indian Elderly: A National Profile*, p.3

7. *Indian Elderly and Entitlement Programs*, National Inian Council on Aging, 1981, p.4

8. Ibid, p.4

9. *The Continuum of Life: Health Concerns of Indian Ellerly*, 2nd National Indian Conference on Aging, 1978, p.4

10. Definition is from the Division of Long Term Care, Halth Resources Administration, Department of Health and Human Servies, p. 6

11. *The American Indian and Alaskan Native Elderly*, p.8

12. U.S. Bureau of the Census, 1970, p.20

13. *Characteristics of Nursing Home Residents, Health Sttus and Care Received*, *National Nursing Home Survey*, U.S. Department of Health and Human Services, National Center for Health Statitics, 1977, p. 24

## APPENDIX A

## Nursing Homes on Indian Land

1. American Indian Nursing Home
Victor Vallet, Director
P.O. Box 9
Laveen, Arizona 85339
(602) 237-2813

2. Blackfeet Nursing Home
Fay Shelby, Director
P.O. Box 728
Browning, Montana 59417
(406) 338-2686

3. Carl T. Curtis Health Education Center and Nursing Home
June Cook, Director
P.O. Box 250
Macy, Nebraska 68039
(402) 837-5381

4. Chinle Nursing Home
Verna Tsosie, Director
P.O. Box 910
Chinle, Arizona 86503
(602) 674-5216

5. Laguna Rainbow Corporation (Elderly Care Center)
Larry Curley, Director
P.O. Box 236
New Laguna, New Mexico 87038
(505) 552-6034

6. Oneida Nursing Facility
Rick Johnson, Director
828 E.E. Road
DePere, Wisconsin 54115
(414) 869-2797

7. Toyei Nursing Home
Alta Blue House Director
P.O. Box 256
Ganado, Arizona 86505
(602) 736-2481

8. White River Elderly Group Home
Raymond Kane, Director
P.O. Box 219
White River, Arizona 85941
(602) 338-4633

## Appendix B

## Questionnaire: American Indian Nursing Homes

1. How many beds do you have in your facility?

2. What are the levels of care offered?

3. How many beds do you have per level of care?

4. What is the usual occupancy? If low, explain why?

5. Do you have a waiting list of potential patients? If so, how large?

6. What are the most common diagnoses for patient admission?

7. What is the average age of occupants?

8. What is the ratio of males to females?

9. What is the average length of stay?

10. What is your admission criteria? (Only reservation, off reservation, financial need)

11. Do you serve one tribe or several?

12. Do you serve non-Indians?

13. How long has your facility been operational?

14. From what source did you receive funds for capital construction?

15. How are you funded for daily operations? (eg. IHS, BIA, Medicare, Medicaid, etc.)

16. What is your annual budget?

17. How many different departments does your facility have?

18. Please give the names and functions of each department?

19. How many total number of staff do you employ?

20. What are the different kinds of staff? Please list professional and non-professional?

21. How many of your staff are American Indian?

22. Do you have any difficulties with staff? If so, what kinds of problems? (high turnover, lack of professional qualifications, unable to recruit Indian personnel. etc.)

23. How does your salary structure compare with urban nursing homes? What about other benefits?

24. Describe your facility, its architectrual layout, incorporation of traditional considerations (i.e. a room for Sings or for the Medicine man to work).

25. If you were to buid a new facility or were able to add space, how would you proceed? What would be different from your current facility?

26. What are the most positive aspects of your current program?

27. What is your greatest concern regarding your facility? (fiscal difficulties, staff turnover, etc.)

28. Is your facility in close proximity to other health care centers? (ie acute care hospital, ambulatory care center, day care center, etc.)

29. What services are offered at your facility? (ie. congregate meals, traditional foods, physical therapy, occupational therapy, recreational therapy, social services, speech therapy, rehabilitation services, adult day care, other)

30. What licenses do you hold? Under whose jurisdiction do you report (ie state, county, federal, JCAH). What accreditating organizations are you affiliated with?

31. Describe the composition of your board of directors? (i.e. Indian, non-Indian, Community leaders, knowledgeable about long term care)

32. Is the board of directors separate from the Tribal Council?

33. Are there any other comments or concerns you would like to share?

## BIBLIOGRAPHY

*A Study of the Indian Health Service and Indian Tribal Involvement in Health*. Urban Associates, DHEW, 1974

*Access: A Demonstration Project: Entitlement Programs for Indian Elders*. National Indian Council on Aging, 1982

*American Indian Elderly: A National Profile*. National Indian Council on Aging, 1981

Edwards, E. Daniel et. al., "American Indian/Alaskan Native Elderly, *Journal of Gerontological Social Work*. Vol. 2 (3), Spring, 1980, p. 213-224.

*Indian Elderly and Entitlement Programs: An Accessing Demonstration Project*. National Indian Council on Aging, 1981

*Report on Indian Health*, *Final Report to the American Indian Policy Review Commission*. U.S. Government Printing Office, Washington, D.C., 1976

*The American Indian and Alaskan Native Elderly*. Technical Report to the White House Conference on Aging, National Indian Council on Aging, 1981.

*The Continuum of Life: Health Concerns of the Indian Elderly*. Second National Indian Conference on Aging, 1978

*The Indian Elder: A Forgotten American*. First National Indian Council on Aging, 1976.